DOCUMENT RESUME

ED 266 609	EC 182 024

TITLE	Early Childhood Special Education Manual.
INSTITUTION	Nevada State Dept. of Education, Carson City.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC. Handicapped Children's Early Education Program.
PUB DATE	81
GRANT	G007902505
NOTE	136p.; Pages 38-50 contain small print.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Classroom Environment; Coordination; Delivery Systems; *Disabilities; *Early Childhood Education; *Handicap Identification; Individualized Education Programs; Program Administration; *Program Development; Student Placement; Teacher Role
IDENTIFIERS	*Nevada

ABSTRACT

Intended as a resource for program planners and implementers, the manual outlines procedures for early childhood special education in Nevada. Eight major topics are addressed in separate chapters: rationale for early childhood special education (economic, child development, family and ethical perspectives, and documentation of effectiveness); identification (casefinding, screening, multidisciplinary evaluation/diagnosis); placement and program (individualized education program development and review, least restrictive environment, service delivery models, caseload, scheduling); personnel (family involvement, teacher competencies, aides and volunteers); program environment (facilities, adaptation and planning of the environment, learning centers, health, safety); program evaluation (child progress, staff development and competency); interagency coordination (analysis of resources and data); and additional references and materials (periodicals, audiovisual and library materials available on loan). (CL)

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EARLY CHILDHOOD SPECIAL EDUCATION MANUAL

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NEVADA DEPARTMENT OF EDUCATION

1981

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This document was produced under a grant from the U.S. Department of Education, Handicapped Children's Early Education Program, P.L. 91-230 as amended. The opinions expressed herein do not necessarily reflect the position or policy of the U.S. Department of Education. Grant No. G007902505.

NEVADA STATE BOARD OF EDUCATION

EARLY CHILDHOOD EDUCATION POSITION STATEMENT

The Nevada State Board of Education does strongly encourage the voluntary planning, implementation and development of programs for early childhood education by the schools of Nevada.

It is the position of the Nevada State Board of Education that early childhood educational programs, when initiated by Nevada schools (public and private), should give special attention to: 1) the handicapped, gifted, and disadvantaged as well as all others; 2) parental involvement; 3) proven and accepted early childhood curriculum and teaching practices which provide ample opportunity for creativity, safety education, and multicultural experience; 4) appropriate learning environment which includes a sound nutritional base (when food is provided) and an adult to child ratio and contact time appropriate to the development levels and identified needs of the children; 5) appropriate concern for the safety, health and well-being of such young children; and 6) emphasis on developmental activities appropriate for young children...... Finally, it is stressed that the above expectations of the Nevada State Board of Education are those identified as justly due such young children placed in the charge of the schools of Nevada.

Adopted 3/21/80

INTRODUCTION AND ACKNOWLEDGMENTS

Nevada's Early Childhood Special Education Manual was developed by and for administrators, consultants, teachers and parents concerned about providing appropriate educational services to children with special needs from birth to five years of age. The document is a product of interagency planning and coordination over a two-year period. During 1979 and 1980, a series of regional interagency planning meetings identified early childhood special education needs in Nevada and articulated topics and concepts that would be appropriate for a resource manual. These meetings were attended by parents, teachers, consultants, and administrators from local school districts, state agencies, universities, colleges, day care centers, preschools, Head Start centers, and private programs throughout the State.

After the major content areas were identified, a group of twenty persons, representing a variety of programs and perspectives, met to develop the Early Childhood Special Education Manual in 1981. These meetings were facilitated and the final development of the document was coordinated by Sharon Palmer, Early Childhood Coordinator for the Nevada Department of Education, Special Education Branch, under the direction of Frank South. It should be noted that this manual is intended to be used as a helpful resource by program planners and implementers and should not be considered a regulatory document.

Special acknowledgment for their time and expertise in the actual development of this manual goes to the following individuals:

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I

RATIONALE FOR EARLY CHILDHOOD SPECIAL EDUCATION

- CRITICAL CHILD DEVELOPMENT PERSPECTIVE
- ECONOMIC PERSPECTIVE
- ETHICAL PERSPECTIVE
- CHILD PERSPECTIVE
- FAMILY PERSPECTIVE
- DOCUMENTATION OF EFFECTIVENESS

RATIONALE FOR EARLY CHILDHOOD SPECIAL EDUCATION

Early childhood special education or early intervention attempts to discover problems and do something about them before a child's development and learning are seriously, perhaps permanently, affected. The early remediation of or attention to developmental delays or deficits can prevent them from producing greater and more complex problems in later years. Arguments for early intervention, from various perspectives, are given below.

CRITICAL CHILD DEVELOPMENT PERSPECTIVE

Burton White (1975), after 17 years of extensive research, confirms that infants and toddlers form the foundations of all later development during the first three years of life. Benjamin Bloom (1964) advocates that 50% of an individual's intelligence, as measured at age 17, develops by age 4 and 30% develops between the ages of 4 to 8 years. That is, 80% of an individual's intelligence develops by age 8. This makes the first eight years, especially the first four years of a child's life, highly significant for future growth. Enough evidence is available showing that the brain nearly triples in size during the first year of life, while the total number of neurons in the central nervous system is established as early as the second trimester of pregnancy. The visual development of a 4-month-old infant is the same as that of a young adult. Downs (1972) reports that 60% of a child's basic language abilities are established by age 2 years. J. McVicker Hunt (1961) supports the point of view that intelligence is not fixed and that facilitative environment impacts immensely on the development of intelligence. Garry McDaniels (1977) emphasizes the significance of the time dimension in the life of a young child, that is, how early a handicapping condition is identified and how much time is devoted in accomplishing the desired objectives. He advocates the earliest possible identification of problems, closer to birth, to prevent deterioration, and devotion of additional time until objectives are achieved. Learning specialists support the concept that in order for learning to occur, a child must be ready to learn and opportunities need to be provided to the child. During the early years of a child's life. there are tremendous amounts of teachable moments. It is only fair to provide opportunities so that the child can learn and, if a child has a problem, to address it right at that time of need, rather than six years later.

ECONOMIC PERSPECTIVE

Spending money on early education programs can often eliminate the greater educational and social costs in later years. Lifetime educational costs of many handicapped children can run over $85,000. Institutionalization can bring total costs to society even higher than $400,000 per child. If we can eliminate or minimize handicaps by early intervention during the critical developmental years, we may be able to save these lifelong costs on many children.

Early recognition and treatment may make the formerly handicapped person an employable, taxpaying citizen. The dollar savings and productive contribution to society is obvious.

Early childhood programs do not always need to follow the traditional classroom model. While such a model may be appropriate in some cases, many children are better served by home teacher/trainers or in an integrated or mainstreamed community preschool. Most young children do not need more than three hours of daily individualized special education. Current Nevada special education standards set caseload sizes for preschool programs operating on half-day schedules. The caseload size limitation varies with the handicapping condition. An itinerant teacher who makes weekly visits to homes or child care facilities could handle a larger caseload, thus reducing the cost per child for services. The type of placement and frequency of contacts would vary with the individual needs of the child. Costs of early childhood special education programs around the nation range from $650 to $4,000 per child depending on the method of service delivery and the amount of time in the program.

Although theoretically there is the same percentage of preschool handicapped children as there are school-aged handicapped children, a much smaller number of preschool problems are identified so early. Only the more obvious handicaps demand early attention.

Many learning disabled preschoolers will still go unidentified until school age. Many articulation problems will not need attention until school age. Many behavior problems will not be recognized by parents until teachers see the child in relationship to others.

ETHICAL PERSPECTIVE

Nevada schools are currently required to identify young handicapped children from birth, but are not mandated to provide special education to children below the age of 5. Some school districts and other state and private programs do offer early childhood special education services, but do not have sufficient resources to serve all identified young handicapped children at the level that their needs require. Such limited services concern parents and service providers who recognize children's needs but are unable to provide adequately for those needs.

There is also a greater potential for abuse to young handicapped children because of the frustration parents and caregivers face in coping with a child with special needs. Early education programs for children and their families can prevent possible child abuse.

Providing support to families and helping handicapped children achieve their highest potential is the right thing to do. The human need is evident and morally compelling.

CHILD PERSPECTIVE

Occasionally neurological, physical or environmental factors may be so severe as to influence a young child's ability to cope with his environment and/or his impulses. In attempting to cope, he may develop or exhibit behaviors that are considered to be indications of emotional disturbance. If these behaviors are permitted to continue during the preschool years and alternative coping mechanisms are not taught, the child may be unable to adequately process the learning that most children can handle easily when they reach school age. The disturbed child can be so preoccupied with his emotional reactions that he cannot attend to other factors in his environment that he should be assimilating. It is crucial that early intervention and training be initiated before the child's learning is affected and faulty behaviors and reactions are firmly implanted.

Many learning problems are related to perceptual handicaps, developmental delays, and immature or inadequate language facility. Early education will provide increased stimulation and training in the weak areas, encouraging a more even development that could eliminate many of the discrepancies in development that are now discovered when the child reaches school age.

Another important consideration regarding cognitive or perceptual delays is that emotional problems may develop as the child wrestles with the frustrations of learning skills that are easy for his/her peers. Such frustrations can lead to poor self-image, hostility and defeat. If delays or disabilities are identified and treated before the regular school age, many emotional complications can be avoided.

All of a child's learning comes from his environment. If sensory or motor handicaps prohibit his movement, he is not able to experience or learn as much as the average child. Much learning is, therefore, lost or delayed because he cannot hear, see, touch, feel, walk, manipulate, etc. When the child reaches school age he will very likely be educationally behind his peers because of the lack of such experiences. A special education program must then be designed to provide those experiences and help him catch up. If certain muscles and senses were not developed, damage or atrophy may prevent their ever developing. Early education for the child with physical or sensory handicaps will provide the training, therapy and adapted environmental stimulation and experiences that will prevent unnecessary permanent loss of function and inadequate learning from the environment.

There is no question about the importance of language and communication in our culture or in our species. Much of our learning comes from the communication we send and receive. Social relationships suffer as a result of poor communication skills, increasing the likelihood of emotional complications. If therapy and additional language training are started early, communication can be greatly improved by the time the child reaches school age. The child will be taught sounds and words and meanings that will help him/her to be successful in school from the beginning and on a more equal footing with peers.

"Recent research in early language development has ... stressed the importance of the first few years in learning cognitive and language skills. Indeed, there are now hundreds of studies which indicate that major components of cognition, syntax and semantics are learned before the age of three and one-half. (Dole, 1976; Muma, 1978.) Therefore, much recent attention has been focused on the possibility of early intervention in the lives of handicapped children to attenuate the deficiencies in their language, speech and hearing development since these deficiencies limit later educability." (From Special Reports, The Availability of Language, Speech, and Hearing Services in Day-Care Centers, "A Journal of the American Speech and Hearing Association, Volume 20, December 1978, p. 1030.)

There is also some evidence to support the crucial importance of developing language before school age because of neurological development of the brain. If damage to certain speech areas of the brain is present, other parts of the brain may be able to take over the function of the damaged portion if therapy is provided as the brain is developing. If we wait too long, that compensatory function may be lost. "Migration of language dominance from its typical habitat in the left hemisphere to residence in the right hemisphere" may be possible. Evidence to support this has been collected by neurosurgical procedures. (Robert T. Wertz, et al. "Right-Hemisphere Language Dominance in a Case of Left-Hemisphere Arteriovenous Malformation," Journal of Speech-Hearing Disorders, Volume 42, February 1977, pp. 106-112.)

FAMILY PERSPECTIVE

The chronic sorrow and early challenge of caring for a handicapped child places great stress on families. Parents need information, intervention and support early before they become discouraged or the family structure is damaged. Participation in intervention activities is within the capability of many more parents when it takes place at an early age while motivation to work with the child is still high. (Refer to Chapter IV.)

DOCUMENTATION OF EFFECTIVENESS

Recent research studies have demonstrated the lasting positive effects of early intervention programs. In the Comptroller General's Report to Congress on February 6, 1979 (U.S. General

Accounting Office, HRD-79-40), the efficacy of early childhood programs was confirmed.

The most comprehensive and conservatively designed study to date was completed in 1979 by the Consortium for Longitudinal Studies under the direction of Dr. Irving Lazar of Cornell University (Lasting Effects After Preschool, U.S. Department of Health, Education and Welfare Publication No. OHDS 79-30179). Data on children in 14 early intervention programs in the 1960's was analyzed for long-term effects. The findings were significant. Children who participated in early developmental programs:

- scored consistently higher on intelligence tests than control group children
- had significantly higher scores on achievement tests
- required special education less often than the control group children who did not participate
- were held back in grade less often than control group children
- had a better family environment and self-image

The study reports that 40% of the children who were provided services did not need special education. 20% were less likely to be retained in class. 37% of the experimental children went to college and acquired skills for independence, whereas only 8% of the controls had acquired jobs. In addition, 79% of the parents reported that their home environment improved and they developed better interpersonal relationships.

Karnes, Shwedel and Lewis (1980) report that after a follow-up study of 86 handicapped children who received early intervention, 65% of those children were making normal progress within regular educational classrooms. Only 20% were in special education classrooms and 15% were retained. Alice Hayden and Associates (1977), while studying long-range impact,'found that 34% of children who had received preschool services from model programs subsequently attended regular classes and were performing as well as their regular classroom peers.

These studies,and many more currently in progress, document and are consistently providing the data that early educational and therapeutic services are reducing the number of children who will need special education services, intensive or long-range help during later years of their lives, thus cutting down immensely the costs for providing special education and institutionalization.

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II

IDENTIFICATION

- CASEFINDING
- SCREENING
- MULTIDISCIPLINARY EVALUATION/ DIAGNOSIS
- IDENTIFICATION OF HANDICAPPING CONDITIONS

IDENTIFICATION

PRIMARY METHODS OF IDENTIFICATION

Identification is the process of locating children who may have special needs and confirming the nature and extent of those special needs so that educational services may be provided. There are four steps in the identification of handicapped children:

1. Casefinding

   Locating children reported to have special needs.

2. Screening

   Confirming reports that a child appears to have some special needs.

3. Multidisciplinary Evaluation/Diagnosis

   Conducting a comprehensive, in-depth measure of the child's functioning to determine nature and extent of his or her special needs.

4. Identifying Handicapping Condition

   Interpreting evaluation data to determine the child's eligibility for special education and related services according to currently accepted categories, definitions and standards.

CASEFINDING/LOCATING

The initial step in the identification process is to obtain the name, address, and telephone number of the child potentially in need of special services. As casefinding is perhaps the most difficult step in the process, a program must often depend on obtaining names, or referrals, from a variety of public and private agencies and individuals. Successful casefinding can be facilitated by contacting agencies and individuals who serve young children and their families, including public health clinics, child care providers, recreation programs, pediatricians, psychologists, and social service workers. Personal contacts followed by written correspondence or information is the most effective way of stimulating referrals. Children with special needs also may be located through public awareness campaigns which use television, newspaper or radio announcements. In geographical areas where many agencies may be involved in casefinding, a high-risk register may be established to coordinate the identification of handicapped children.

SCREENING

This step involves initial collection of information about the child to see if he/she is an appropriate candidate for further diagnostic evaluation and services. Initial screening is conducted to confirm that a child may have some disability and to eliminate the child who does not in fact have a problem, or for some particular reason is not eligible for intervention.

Screening procedures may include interview, testing, or child observation, but should be quick, inexpensive, and useable by trained paraprofessionals as well as professionals.

Screening should take place as early as possible in a child's life. Children who may be at risk for developing special needs should be rescreened on a continuous basis. The earlier screening is conducted, the more quickly a child can be placed in a program and receive the benefits of early intervention. Early screening also provides more time for the special education program to prepare for the numbers of children who may need services.

Screening is NOT assessment. No child is diagnosed or recommended for special education services based on screening alone.

WHAT IS THE DIFFERENCE BETWEEN SCREENING AND EVALUATION?

As compared to evaluation, screening is a limited procedure. Screening can merely indicate that a child may have a handicap. It cannot describe the nature and extent of a handicap. Screening must be followed by evaluation in order to confirm or disconfirm the suspicions raised. Screening tools are used to select children who may possibly have special needs and need further evaluation; evaluative instruments are chosen to identify those children who in fact do have special needs. Screening should not be used to label children or to develop intervention procedures. It is only after comprehensive evaluation that the existence of a handicapping condition can be determined, an individual educational plan can be developed, and the appropriate services can be recommended. Screening does not determine a child's I.Q. Screening is less reliable with the younger child. Further evaluation, or rescreening, may disconfirm the initial screening results.

HOW IS SCREENING CONDUCTED?

There are several steps to successful screening of young children. They are:

1. Involve Parents in Planning and Implementation

According to the most recent federal rules and regulations for special education, programs need not require parental consent to screen large numbers of children in order to determine those children who might need diagnostic assessment. However, direct and indirect parental involvement is usually important for successful screening. It is good educational practice to begin to involve parents at the beginning of the identification process. It demonstrates that their rights are respected and paves the way for further cooperation.

Indirect involvement consists of providing the parent with information regarding the screening. Parents should be told what a screening program consists of, what its rationale may be, how it may fit into the child's overall educational plan, who will perform the screening, when and where it will take place, how confidentiality will be handled and how results will be communicated. Rights and feelings must be carefully guarded. For a number of families, screening represents a first exposure to a service program. Chaotic reception rooms, long waiting lines and uninformed personnel should not be used.

The parent may be directly involved in the screening process if an interview or parent rating instrument is used. The parent should at least be invited to attend screening sessions, but should not be required to observe his/her child's screening. In some cases, it is easier and less anxiety-provoking for parent and child to be separated for the actual screening. Discretion should be utilized.

If a parental permission form is used, it may be part of the parent interview form at the screening or may be mailed to the parents prior to bringing the child to the screening site. Depending on the confidentiality procedures governing the transfer of records between agencies in your community, the parental permission form for screening could also include permission to release screening results to other agencies as appropriate. Obtaining consent at the screening saves time and effort later as it is determined that the child needs assessment.

There is an advantage if the same parental permission forms or screening procedures are used by all community agencies. This could assist the follow-up and referral processes between agencies.

2. Outline Objectives and Identify Target Populations to be Screened

The program should look at the needs of the area or community before defining the target populations. In doing this, it may be helpful to address the following questions:

- What particular age range will be emphasized?
- Approximately how many children will be screened?
- What geographic location will be covered?
- For other agencies, will there be eligibility requirements?
- Will transportation be an issue?

Children who have obvious handicapping conditions such as blindness or a physical handicap should not have to participate in screening. These children can frequently be identified during the initial referral and can enter the evaluation phase immediately.

Infants such as those with cranial facial anomalies or physical disorders are easily identified by competent medical doctors, psychologists or educators. A large number, approximately two-thirds of these children, will be identified by neonatologists in the first days of life. Of the remaining one-third, the majority will be called to a pediatrician's attention before the first birthday. Medical practitioners and parents should be made aware of the programs available to such developmentally disabled children.

Children identified as "at risk" for a handicapping condition are most often the targets of a screening program. At-risk indicators include:

- Family history of genetic disorder.
- Detrimental prenatal influences such as infection or substance abuse.
- Low birth weight or prematurity.
- Birth trauma.
- Medical problems in infancy, including allergy.

- Low socioeconomic status.

- Age, emotional, and physical status of mother.

3. Select a Screening Coordinator and Personnel Who Will Conduct the Screening

   - One individual should be appointed who will be responsible for the development and coordination of the total screening program.

   - A committee of professionals or involved citizens may be appointed for planning and implementation of the screening program.

   - Paraprofessionals, parents (guardians), and volunteers can be trained to administer most screening tools for young children. This activity can foster community involvement and public awareness.

   - Develop projections about the number of screeners needed, consider requirements of the screening instruments, target population, and geographical scope of the program when deciding who will administer portions of the screening program.

4. Establish Appropriate Community Sites for Screening

   Visit several potential sites to determine the most appropriate facility. The extent of interagency cooperation may help determine the options available. The estimated number of children to be screened at one time is a consideration, as well as accessibility of the site to various members of the community. The following are some suggested screening sites: public schools, preschool and day care programs, health care settings, other community agencies and the child's home.

5. Select Screening Instruments to be Used

   In selecting screening instruments, the objectives of the screening program should be considered. Screening may be conducted for the sole purpose of identifying a particular handicapping condition, such as speech and language delay. However, a comprehensive screening program usually includes instruments which measure the child's present functioning level in the following areas:

   - Medical (i.e., lead poisoning, sickle-cell anemia, tubercular sensitivity, PKU, and metabolic screening).

   - Social-emotional development.

   - Motor development

- Perceptual-cognitive development.

- Speech and language (expressive and receptive skills).

- Self-help skills.

Screening instruments for young children may also include measures of school readiness and preacademic development. Multiple screening instruments may be used, although some instruments, such as the CIP (Comprehensive Identification Process) have been developed to screen across all relevant areas.

The following criteria should be considered in selecting screening instruments:

- Is the instrument reliable and valid?

- Are normative scores available on a population similar to yours?

- How long will the screening take?

- How old are the children who are to be screened?

- Is the instrument available in more than one language, and is it fair to children from different cultures?

- Is the screening test experience pleasant for most children?

- Is it difficult to learn how to administer the instrument?

- Is the instrument expensive, or does it utilize costly apparatus?

(Suggested screening instruments are listed at the end of this chapter.)

6. Plan and Implement Public Awareness

Dissemination of information regarding screening program could include: a) letters to parents (guardians) identified, b) letters to school personnel when the screening is a cooperative effort, c) news releases, d) radio and TV spots, community flyers, etc.

7. Train Screening Personnel

Personnel chosen for conducting the screening instruments need to be familiar with the instruments. This may be done through a structured inservice program prior to the screening.

8. Implement Screenings

Screenings should be implemented by the identified and trained personnel.

9. Data Interpretation

Programs may vary in methods of interpreting screening results. Parents (guardians) need some form of immediate feedback. Feedback must be presented in a meaningful way. There must be a set plan for providing screening results whether it be immediately or at a later date through conference or letter.

10. Collect and Analyze Data

Interpret the data on each child screened for the purpose of identifying children who need to be referred for evaluations.

MULTIDISCIPLINARY EVALUATION/DIAGNOSIS*

Evaluation (assessment) procedures are used to determine whether a child is handicapped and the nature and extent of the child's needs with regard to special education and related services. Regulations indicate general procedures to be adapted to each individual child and do not mandate specific tests or procedures to be used with all children in a given program or age range. Diagnosis refers to a statement which synthesizes information collected during the evaluation and screening process. Evaluation/Diagnosis involves an in-depth, comprehensive measurement of the child's abilities/level of functioning. This process confirms or refutes initial impressions of the child collected during the screening process, positively identifying any handicapping conditions and recommending special education services appropriate to these conditions. The results of the evaluation/diagnosis are later used to assist in the development of the child's individualized educational plan (IEP) (see Chapter III). Although the ultimate goal of the evaluation/diagnosis is to recommend some type of intervention program, this process does not determine placement of the child in any particular program.

CONDUCTING THE EVALUATION

The following procedures are recommended in completing a thorough evaluation of the child:

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*For the purposes of this document, "assessment" and "evaluation" are used interchangeably.

1. Parental permission must be obtained. Similar precautions regarding parent involvement listed earlier under the screening section apply to the evaluation section of this document. The parents (guardian) of any child referred for evaluation should be informed of the referral as well as the conclusions of the preliminary assessment. Prior to any other evaluation, agency personnel should give parents (guardian) the reasons for the evaluation and the opportunity for a face-to-face conference with program personnel in a language which is appropriate.

2. Appropriately qualified professionals should conduct the evaluation. If the child has special needs in more than one area of functioning, experts in each of these areas should participate in the evaluation.

3. Evaluation instruments should be used that are reliable, valid, culture-fair, and appropriate to the child's age. More than one instrument should be used to confirm the child's handicapping condition(s). (Suggested evaluation instruments are listed at the end of this chapter.)

4. Evaluation instruments should provide more information on suspected handicapping conditions as revealed through the screening process. Although evaluation instruments need only be administered in the suspected areas of need, measurement of the young child's functioning in other areas is important at the time of evaluation, since changes may occur between the time of screening and evaluation.

5. The evaluation should be conducted in the child's native language.

6. At least one of the evaluation instruments should involve direct contact with the child. If this is not possible, the child's behavior/functioning should be informally observed and described.

7. It is useful to collect parent report and family history. This information may be relevant to the type of services recommended for the child.

INTERPRETING TEST DATA

Ideally, after completing the evaluation, a written report containing the following from those who conducted the evaluation is submitted to the IEP committee:

- A comprehensive description of the level of functioning, using both screening and evaluation measures.
- Observation data, if collected.
- Medical/biographical information as relevant.
- Recommendation for special education services relative to child's special needs.

The evaluators should certify whether the report recommendations reflect their opinion. This report will be used in developing the child's intervention program.

SHORT-TERM EVALUATIONS

In some instances, information and further assessment is needed by the placement committee to help write a comprehensive IEP and determine an appropriate placement. The child may be assigned to a program on a preliminary basis for approximately 30 calendar days. Before making the assignment, the IEP committee would meet in order to develop a preliminary IEP. (Refer to section on IEPs in Chapter III.)

REEVALUATIONS

Reevaluations should be conducted:

- When the child is not progressing as expected.
- When the parents (guardian) make a request or the IEP committee agrees that more evaluation information is needed to plan an appropriate educational program.
- Whenever the semiannual or annual IEP review by the placement committee suggests that it is needed.
- At least once every three years or sooner depending on age and progress.

IDENTIFICATION OF HANDICAPPING CONDITIONS

Identifying the preschool handicapped population by category is difficult for a number of reasons, including great variability in normal development, questionable diagnostic instruments, differences in quality and quantity of environmental experiences, and program philosophy. In order to ensure a reduced probability of misdiagnosis, the requirements for a preschool handicapped population definition must be carefully developed. Numerous problems are caused by vague definitions and the relative infancy of this area of special education. Definitions or specific standards for early identification are needed so that every child has educational opportunities as early as possible in the critical developmental years.

Nevada Revised Statutes currently list the following categories of handicapping conditions:

- Academically Talented
- Aurally Handicapped
- Seriously Emotionally Handicapped
- Learning Disabilities
- Mentally Handicapped
- Multiple Handicapped
- Physically Handicapped
- Speech Handicapped
- Visually Handicapped

Definitions, eligibility descriptions, and evaluation standards for each of these categories are outlined in the Standards for Administration of Special Education Programs adopted by the Nevada State Board of Education.

A categorical approach is needed for identifying, counting and maintaining data to appropriately fund special education programs for the handicapped population, but early childhood special education programs may choose to identify their students with descriptive terminology that can be translated into the current state and federal categories for data purposes.

Until Nevada's Standards are expanded or translated into early childhood terms, a program may choose to select terminology such as "at risk" for developing mental retardation, learning disabilities, serious emotional disturbance, etc. Another approach might be to describe young children as "significantly developmentally delayed" in the speech, language, cognitive, emotional, motor, perceptual or sensory areas.

Index of Assessment and Evaluation Instruments

Co-operatively Developed by
The North Carolina
Department of Public Instruction
and
The Mid-East Regional Resource Center

INTRODUCTION

The information contained within this document was obtained from a variety of sources: commercial producers, the Coordinating Office for Regional Resource Centers, and the test users. Because of the divergent input, there have been some subjective judgements made in the categories describing instrument usage. These descriptions are not to be understood as those necessarily recommended by the commercial producers but are those recommended by users (i.e., clinicians, diagnosticians, psychologists, teachers, etc.).

Additionally, the instruments included herein are by no means a complete list of all that is available to the consumer. They are meant to be representative of the most widely used and currently accepted assessment devices. You are encouraged to write the commercial producers to obtain further information on these devices as well as other equally appropriate instruments. To facilitate this, there is included a list of commercial producers. Prices indicated are subject to change without notice.

It must be remembered by those who administer standardized assessment devices that the function of testing is but one aspect of the assessment process. Interpretation of results, the formulation of an educational prescription, and the implementation of that prescription via available resources must all be equally weighted. To have one or more of these components without having all of them will slow or negate entirely the effectiveness of the diagnosis.

Compiled by:

Dr. John A. Haigh and Richard Olson

LIST OF COMMERCIAL PRODUCERS

Adapt Press [(605) 336-2377]
808 West Avenue North
Sioux Falls, South Dakota 57104
"A Diagnostic & Prescriptive Technique" (ADAPT): $17.95

Allyn & Bacon, Inc. [(617) 482-9220]
470 Atlantic Avenue
Boston, Massachusetts 02110
"Handbook in Diagnostic Teaching"

American Association of Mental Deficiency [(202) 244-8143]
5201 Connecticut Avenue, N.W.
Washington, D.C. 20015
"Adaptive Behavior Scale": $6.00 or $13.00

American Foundation for the Blind [(212) 924-0420]
15 West 16th Street
New York, New York 10011
"Maxfield-Bucholz Scale for Social Maturity": $2.00

American Guidance Service [(621) 786-4343]
Publishers' Building
Circle Pines, Minnesota 55041
"Vineland School Maturity": $2.00
"First Grade Screening Test": $3.50
"Goldman-Fristoe Test of Articulation": $21.70*
"Key Math": $22.70*
"Peabody Individual Achievement Test": $36.00*
"Peabody Picture Vocabulary": $18.50*
"Verbal Language Development Scale": $1.00
"Preschool Attainment Record": $1.85

American Orthopsychiatric Association [(212) 586-5690]
1775 Broadway
New York, New York 10019
"Bender-Gestalt Visual Motor": $3.00

Bobbs-Merrill Company [(317) 291-3100]
4300 West 62nd Street
Indianapolis, Indiana 46206
"Detroit Tests of Learning Aptitude": $9.05

*indicates specimen set

Bureau of Educational Research and Service [(319) 353-3823]
C-6 East Hall
The University of Iowa
Iowa City, Iowa 52204
"Templin-Darley Tests of Articulation": $5.40

Camelot Behavioral Systems [(316) 421-9095]
P.O. Box 607
Parsons, Kansas 67357
"Camelot Behavioral Checklist": $2.75

Charles E. Merrill Publishing Company [(614) 258-8441]
1300 Alum Creek Drive
Columbus, Ohio 43216
"Purdue Perceptual Motor Survey": $15.46

Instructional Media, Inc. [(918) 622-4522]
Attn: Carolyn Davis
4235 South Memorial
Tulsa, Oklahoma 74145
"Thomas Self Concept"

Consulting Psychologists Press, Inc. [(415) 326-4448]
577 College Avenue
Palo Alto, California 94306
"Cain Levine Social Competencies Scale": $1.75
"Frostig Development Test of Visual Perception": $5.00

Counselor Recordings and Tests [(615) 292-5201]
Box 6184
Acklen Station
Nashville, Tennessee 37212
"Piers-Harris Children's Self Concept Scale": $1.50
"Tennessee Self Concept Scale": $1.50

The Devereux Foundation Press [(215) 687-3000]
Devon, Pennsylvania 19333
"Devereux Adolescent Behavior Rating": $1.15
"Devereux Child Behavior Rating": $1.15
"Devereux Elementary School Behavior Rating": $1.15

Educational Performance Associates
Distributor: Reporting Service for Children
563 Westview Avenue
Ridgefield, New Jersey 07657
"TMR Performance Profile": $15.00

Educators Publishing Service [(617) 547-6706]
301 Vassar Street
Cambridge, Massachusetts 02139
"Slingerland": $4.00

Expression Company [(617) 426-2685]
155 Columbus Avenue
Boston, Massachusetts
"Robbins Speech Sound Discrimination & Verbal Imagery Test": $2.50

Fearon Publishers [(415) 592-7610]
Lear Siegler, Inc., Education Division
6 Davis Drive
Belmont, California 94002
"Psychoeducational Inventory of Basic Learning Abilities": $1.00

Follett Educational Corporation [(312) 666-5855]
P.O. Box 5705
Chicago, Illinois 60680
"Beery Test of Visual Perception": $2.10
"Basic Concept Inventory": $27.00*

Guidance Associates of Delaware, Inc. [(302) 652-4990]
1526 Gilpin Avenue
Wilmington, Delaware 19806
"Wide Range Achievement Test": $5.40

Harcourt, Brace, Jovanovich, Inc. [(212) 572-5000]
757 Third Avenue
New York, New York 10017
"Durrell Analysis of Reading Difficulty": $8.75*
"Metropolitan Achievement Test": $11.25-$28.00* (depending)
"Stanford Achievement Test": $8.25-$32.50* (on level)
"Columbia Mental Maturity Test": $50.00
"Draw A Man": $5.75*

Houghton Mifflin Company [(212) 867-8050]
53 West 43rd Street
New York, New York 10036
"Monroe Reading Aptitude Tests": $6.00
"Iowa Test of Basic Skills": Approx. $10.00-$45.00 (depending on level)
"Binet": $75.00

Interstate Printers and Publishers [(217) 446-0500]
19-27 North Jackson Street
Danville, Illinois 61832
"Photo Articulation Test": $12.95

Ladoca Project and Publishing Foundation [(302) 222-3605]
East 51st Avenue and Lincoln Street
Denver, Colorado 80216
"Denver Developmental Screening Test": $6.25

Language Research Associates, Inc. [(312) 787-1123]
175 East Delaware Place
Chicago, Illinois 60611
"Wepman Auditory Discrimination Test"

Marshall S. Hiskey [(402) 466-6145]
5640 Baldwin Avenue
Lincoln, Nebraska 68507
"Hiskey-Nebraska Test of Learning Aptitude": $60.00*

McGraw-Hill/CTB [(609) 448-1700]
Princeton Road S-2
Hightstown, New Jersey 08520
"Lee Clark Reading Test": $1.25
"KELP"
"California Achievement Tests": $3.00

Programs for Education
Lumberville, Pennsylvania
"Gesell Developmental Tests": $10.95

The Psychological Corporation [(212) 679-7070]
304 East 45th Street
New York, New York 10017
"Examining for Aphasia": $9.00
"Harris Test of Lateral Dominance": $1.75
"Raven's Progressive Matrices": $3.75
"Bayley Scales of Infant Development": $93.00
"Benton Visual Retention Test": $6.80
"Bohem Test of Basic Concepts": $1.00
"McCarthy Scales": $59.90
"WISC": $29.50
"WISC-R": $35.00

Psychological Test Specialists
Box 1441
Missoula, Montana 59801
"Kahn Intelligence Test": $52.00*

Slosson Educational Publications [(716) 652-0930]
140 Pine Street
East Aurora, New York 14052
"Slosson Intelligence Test": $7.50

Science Research Associates [(312) 944-7552]
259 East Erie Street
Chicago, Illinois 60611
"SRA Achievement Test": $1.70-$2.75 (depending on level)

Stanwix House [(412) 771-4233]
3020 Chartiers Avenue
Pittsburg, Pennsylvania 15204
"DEEP Test of Articulation"

Stoelting Company [(313) 722-3833]
424 North Homan Avenue
Chicago, Illinois 60624
"Lincoln-Oseretsky": $43.50*

Teachers College Press [(212) 870-4215]
Teachers College
Columbia University
New York, New York 10027
"Gates-MacGintie Reading Test"

Teaching Resources Corporation [(617) 357-8446]
100 Boylston Street
Boston, Massachusetts 02116
"Pupil Record of Educational Behavior": $62.84

University Book Store [(317) 743-1289]
Purdue University
360 State Street
West Lafayette, Indiana 47906
"Handicap Problems Inventory": $1.25

University of Illinois Press [(217) 333-0950]
Urbana, Illinois 61801
"Illinois Test of Psycholinguistic Abilities" (ITPA): $58.00*

Western Psychological Services [(213) 478-6730]
12031 Wilshire Blvd.
Los Angeles, California 90025
"Ayres Space Test": $25.00
"Arizona Articulation Proficiency Scale": $18.50

*Indicates specimen set

This work was performed pursuant to Office of Education contract 0-74-7903 from the U.S. Department of Health, Education and Welfare, Office of Education. However, the opinions expressed herein do not necessarily reflect the position or policy of the U.S. Office of Education, and no official endorsement by the U.S. Office of Education should be inferred.

BEST COPY AVAILABLE

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Achievement Tests—																														
Calif Achieve Tests-McGraw-Hill	x	x	x	x	Grades 1.5-2.5,	171, 177, 212		x		x		x	x								x		x							
					2.5-4.5, 4-6, 6-9, 9-12	198, 267																								
Iowa Test of Basic Skills—		x	x		Grades 1.7-3.5, 3-9	340, 365, 80		x		x		x	x										x					x	x	
Houghton Mifflin																														
Key Math Diag. Arith. Test—	x			x	K-6	30	x			x											x		x							
American Guidance																														
Metropolitan Achieve. Test.—H B.J.	x	x	x		K-1.4, 1.5-2.4, 2.5-3.4,	120, 125, 170		x		x		x						x			x		x							
					3.5-4.9, 5-6.9, 7-9.5	235, 320, 315																								
S R A Achieve. Test.—S.R.A.	x	x	x		Grades 1-2, 2-4, 4-9	340, 365, 80		x		x		x								x			x							x
Stanford Achieve. Test—H B J.	x	x	x	x	Grades 1.5-2.4, 2.5-3.9,	160, 235, 300		x		x								x					x							
					4.-5.4, 5.5-6.9, 7.-9.9	803, 287																								
Wide Range Achieve Test—	x	x		x	6-10 yrs, 11, 12 & over	20-30	x	x		x											x	x	x							
Guidance Assoc. of Delaware																														
Personality & Aptitude—																														
Devereux Adolescent Rating	x			x	3-18 yrs	15				x						x						x								
Scale-Devereux Found.																														
Devereux Child Behavior Rating	x			x	8-12 yrs	10-20		x		x						x						x								
Scale-Devereux Found.																														
Devereux Elementary School	x			x	K-6	10		x		x						x						x								
Behavior Rating-Devereux Fd.																														

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	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Adaptive Behavior Scales																														
A D A P T —Farrald & Schamber	x			x	Developmental	—	x	x			x	x		x	x	x	x		x			x					x			
Adaptive Behavior Scale-Am. Assoc. on Mental Deficiency		x		x	3-13, 13 yrs & over	20-30	x	x		x						x			x		x									
Camelot Behavioral Checklist— Camelot Behavioral Systems	x			x	No Age Limit	Untimed		x	x					x		x		x	x		x									
Devereux Adolescent Behavior Rating- Devereux Foundation	x			x	2 wks-6 yrs	15-20	x	x		x			x	x		x			x		x									
Devereux Child Behavior Rating- Devereux Foundation	x			x	8-12 yrs	10-20		x		x						x						x								
Devereux Elementary School Behav. Rating-Devereux Foundation	x			x	K-6	10	x		x							x						x								
Maxfield-Bucholz Scale of Social Maturity for use with Blind Children-Am. Found. for the Blind	x			x	Infancy-6 yrs	Untimed		x		x								x	x			x							x	
Pre-School Attainment Record- American Guidance	x	x		x	2.5-18 yrs	15-20	x	x		x								x	x		x									
T.A.R.C.-Topeka Assoc. for Retarded Citizens	x			x	3-16 yrs	Untimed	x	x		x			x	x		x		x	x			x								
T.M.R. Performance Profile- Educ. Performance Assoc.	x	x		x	Open	Untimed	x	x	x										x		x	x								
Vineland Social Maturity- American Guidance	x	x		x	0-13 yrs	20-30		x	x		x								x		x	x								

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Intelligence Tests																														
Bayley Scales of Infant Develop.-	x	x		x	0-30 mo.	—								x							x	x								
Psychological Corp.																														
Benton Visual Retention Test-		x		x	8 yrs. & over	50		x		x		x		x								x								x
Psychological Corp.																														
Binet-Houghton Mifflin	x	x	x	x	2 yrs. & over	30-90		x		x		x	x								x									
Boehm Test of Basic Concepts	x.		x		K-2	40									x						x	x								
Psychological Corp.																														
Columbia Mental Maturity Test-		x		x	3-12 yrs.	15-20		x		x		x									x	x		x	x	x				
H.B.J.																														
Denver Develop. Screening Test	x			x	2 wks.-6 yrs.	15-20	x	x		x			x	x					x		x									
Ladoca Proj.																														
Detroit Tests of Lrng. Apt.-		x		x	3 yrs. & over	60-95	x	x		x	x	x		x							x									
Bobbs Merrill																														
Gesell Develop. Tests-Pgms.		x		x	5-10 yrs.	20-30		x		x								x			x									
for Education																														
Goodenough-Harris Draw-A-	x	x	x		3-5 yrs.	10-15		x		x										x		x								
Man Test—H.B.J																						x		x	x	x				
Hiskey-Nebraska Test of Lrng.		x		x	3-18 yrs.	45-60		x		x																				
Aptitude—Author																														
Kahn Intelligence Test-	x	x		x	1 mo. & over	—	x			x												x						x	x	
Psycholog. Test Spec																														
McCarthy Scales-Psychological	x			x	2½—8½ yrs.	—	x	x	x		x	x	x	x	x			x			x	x								x
Corp																														
Pre-School Attainment Record-	x	x		x	6 mo.-7 yrs.	untimed	x	x		x									x		x									
American Guidance																														
Peabody Picture Vocab. Test-	x	x		x	2.5-18 yrs.	15-20	x	x		x		x						x			x	x		x						
American Guidance																														
Raven's Progressive Matrices-	x		x		6 yrs. & over, 5-11,	60, 30, 50		x		x											x		x							
Psychological Corp					11 yrs. & over																									
Slosson Intel. Test-	x	x		x	1 mo. & over-0-30	0-30	x		x			x						x			x									
Slosson Ed. Pub.																														
WISC & WISC-R—NFER		x		x	5-15 yrs.	—	x	x		x	x	x	x	x							x	x								

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Learning Disabilities & Reading																														
A D A P T Farrald & Schamber	x			x	Developmental	—	x	x			x	x		x	x	x	x		x			x								
Arizona Articulation Prof. Scale		x		x	2-14 yrs. & over	20-30	x			x	x	x					x					x					x			
W Psychological Ser																														
Ayres Space Test- W Psycho Ser.		x		x	3 yrs. & over	20-30		x		x		x		x								x								x
Basic Concepts Inventory-	x	x		x	3-10 yrs.	15-25	x	x	x											x	x									
Follett																														
Beery Test of Visual Percept.-	x	x	x	x	2-8 yrs., 2-15 yrs.	10, 10		x		x		x									x									x
Follett																														
Bender-Gestalt Visual Motor-		x	x	x	4 yrs. & over	10		x		x		x		x								x								x
Am Orthopsychiatric Assoc.																														
DEEP Test of Articulation-	x	x		x	Grades 2 & under,	—	x		x								x					x					x			
Stanwix House					3 yrs. & over																									
Durrell Ana of Reading Difficulty-	x	x		x	Grades 1-6	30-90	x		x		x	x	x				x				x	x								
H B J																														
Examining for Aphasia-		x		x	Adolescent & Adult	30-120	x	x	x		x	x		x								x								x
Psychological Corp.																														
First Grade Screening Test-	x		x		5-7 yrs.	K-45, 1-30		x		x					x				x		x									
American Guidance																														
Frostig Devel. Test of Visual Percept.	x	x	x	x	3-8 yrs.	30-45		x		x		x		x				x				x								x
Consulting Psycho.																														
Gesell Devel. Tests-Progms. for Ed.		x		x	5-10 yrs.	20-30		x		x								x			x									
Goldman-Fristoe Test of Artic.-	x	x		x	2 yrs. & over	10	x		x								x					x					x			
American Guidance																														
Goldman-Fristoe-Woodcock Test	x	x		x	4 yrs. & over	15-20		x		x	x										x	x					x			
of Auditory Discrim -Am. Guid.																														
Harris Test of Lateral Dom.-		x		x	7 yrs. & over	10-15		x	x					x								x								
Psychological Corp.																														
I T P A -Univ. of Illinois	x	x		x	2-10 yrs.	45-60	x	x		x	x	x	x									x		x	x	x	x	x	x	
Lee-Clark Reading Test-McGraw-Hill	x		x	x	Grades 1-2	20-30		x		x	x	x										x								
Lincoln-Oseretsky Tests of	x	x		x	6-14 yrs.	30-60		x		x				x							x	x								
Motor Prof -Stoelting																														
Mann-Suiter-Allyn & Bacon	x		x	x	K-5	—	x	x		x	x	x	x	x				x				x		x						
Monroe Reading Aptitude Tests-	x	x	x	x	K-1	40-55	x	x		x	x	x	x	x			x					x								
Houghton-Mifflin																														

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
L.D. & Read. Cont.																														
Photo Articulation Test Interstate		x		x	3-12 yrs.	2-20	x		x		x						x					x			x		x			
Peabody Indiv. Achievement Test- Am. Guidance	x	x		x	2.5-18 yrs.	15-20	x	x		x		x						x			x	x		x						
Peabody Picture Vocab. Test- Am. Guidance	x	x		x	2.5-18 yrs.	15-20	x	x		x		x						x			x	x		x						
Psychoeducational Inven. of Basic Learning Abil.-Ferron	x			x	5-12 yrs.	—	x	x	x			x	x	x	x				x			x								
Pupil Record of Ed. Behavior- NY Teach. Resource	x			x	K-6	30-120	x	x	x		x	x	x	x				x			x	x								
Purdue Perceptual-Motor Survey Charles E. Merrill	x	x		x	6-10 yrs.	20		x		x		x		x							x	x		x						
Raven's Progressive Matrices- Psychological Corp.	x		x		6 yrs. & over, 5-11 11 & over	60, 30, 50		x		x										x			x							
Robbins Speech Sound Discrim. & Verbal Imag. Test-Expression		x		x	4-8 yrs., 8 & over	60	x	x	x			x	x				x					x			x		x			
Slingerland-Ed. Pub. Ser. Inc.	x		x		Grades 1-4	2 days	x	x		x		x	x		x							x								
Templin-Darley Tests of Artic. Bur. of Ed. Resh. & Ser.		x		x	3 yrs. & over	5-15, 20-40	x			x							x				x	x					x			
Verbal Lang. Develop. Scale- American Guidance	x	x		x	0-15 yrs.	30	x			x			x									x					x			
Wepman Auditory Discrim. Test- Lang. Resh. Assoc.	x	x		x	5-9 yrs.	5	x			x	x										x	x					x			
Gates-MacGinitie Reading Test- Teach. Col. Press	x		x		Grades 2, 3, 2.5-3 4-6, 7-9	50, 50, 60 15, 60, 60		x		x		x									x									

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ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Personality Tests-(Nonprojective)																														
Adaptive Behavior Scale-Am. Assoc on Mental Deficiency		x		x	3-13, 13 yrs. & over	20-30	x	x		x						x			x		x									
Ayres Space Test-W. Psy. Ser.		x		x	3 yrs. & over	20-30		x		x		x		x								x								
Cain Levine Social Compt. Scale-Consult. Psy.	x	x		x	5-13 yrs.	untimed	x	x		x									x		x									
Camelot Behavioral Checklist-Camelot	x			x	No Age Limit	untimed		x	x					x		x		x	x		x									
Devereux Adolescent Behavior Ratings-Devereux	x			x	2 wks-6 yrs.	15-20	x	x		x			x	x					x		x									
Devereux Child Behavior Rating-Devereux	x			x	8-12 yrs.	10-20		x		x						x						x								
Devereux Elementary Schl Behavior Rating-Devereux	x			x	K-6	10		x		x						x						x								
Maxfield-Bucholz Scale of Social Maturity for use with Blind Children-Am. Found. for the Blind	x			x	Infancy-6 yrs.	untimed		x	x									x	x			x							x	
Piers-Harris Children's Self Concept Scale-Couns. Rec. & Test.	x	x	x	x	3 yrs.-Grade 12	15-20	x	x		x					x							x								
Tennessee Self Concept Scale-Couns. Rec. & Tst.	x	x	x	x	12 yrs. & Over	10-20		x		x					x				x		x	x								
Handicap Problems Inventory-Univ. Bookstore		x		x	16 yrs. & over	30-35	x			x					x							x		x						
Thomas Self Concept Values Test Comb. Motiv. Ed. Sys.	x	x		x	3-9 yrs.	10-20	x		x						x							x								
TMR Performance Profile-Ed. Perform. Assoc.	x	x		x	open	untimed	x	x	x										x		x	x								
Vineland Social Maturity-Am. Guidance	x	x		x	0-13 yrs.	20-30	x	x		x									x		x	x								
Personality Tests- (Projective)																														
Bender-Gestalt Visual Motor-Am. Orth. Assoc.		x	x	x	4 yrs. & over	10		x		x		x		x								x								x

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE/ GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Pre School & Primary																														
Basic Concept Inventory-	x	x		x	3-10 yrs.	15-25	x	x	x																					
Follett																				x	x									
Bayley Scales of Infant Dev.-	x	x		x	0-30 mo.																									
Psychological Corp.														x							x	x								
Boehm Test of Basic Concepts-Psych. Corp.	x		x		K-2	40																								
Denver Dev. Screening Test-	x			x	2 wks.-6 yrs.	15-20	x	x		x					x						x	x								
Ladoca Project													x	x					x		x									
Gates-MacGinitie Reading	x		x		Grades 2, 3, 2.5-3,	50, 50, 60		x		x																				
Test-Tchs. Col. Press					4-6, 7-9	15, 60, 60						x										x								
Gesell Dev. Tests-Pgms. for Ed.		x		x	5-10 yrs.	20-30		x		x																				
KELP-McGraw Hill	x		x	x	K	—	x	x	x									x			x									
Pre-School Attainment Record	x	x		x	6 mo.-7 yrs.	untimed	x	x		x	x	x	x	x				x			x	x	x							
Am Guidance																			x		x									

ASSESSMENT DEVICES AND PUBLISHER	ADMINISTRATIVE						RESPONSE MADE		REFERENCE		CONTENT										EMPHASIS			CATEGORY						
	TEACHER ADMINISTERED	DIAGNOSTICIAN ADMINISTERED	GROUP ADMINISTERED	INDIVIDUAL ADMINISTERED	AGE / GRADE	TIME REQUIRED MINUTES	VERBAL	NON-VERBAL	CRITERION	NORMATIVE	AUDITORY PERCEPTION	VISUAL PERCEPTION	LANGUAGE DEVELOPMENT	MOTOR DEVELOPMENT	SELF CONCEPT	BEHAVIOR	ARTICULATION	SCHOOL READINESS	SOCIAL DEVELOPMENT	CONCEPT INVENTORY	SCREENING	DIAGNOSTIC	ACHIEVEMENT	PHYSICALLY HANDICAPPED	HARD OF HEARING	DEAF	SPEECH IMPAIRMENT	VISUAL HANDICAPPED	BLIND	VISUAL PERCEPTION
Sensory Motor Proficiency																														
Arizona Articulation Prof. Scale-		x		x	2-14 yrs. & Over	20-30	x			x	x	x					x					x					x			
W Psychological Ser.																														
Ayres Space Test-W Psycho. Ser.		x		x	3 yrs. & over	20-30		x		x		x		x								x								x
Bender-Gestalt Visual Motor-		x	x	x	4 yrs. & over	10		x		x		x		x								x								
Am. Orthopsychiatric Assoc																														
Beery Test of Visual Perception-	x	x	x	x	2-8 yrs., 2-15 yrs.	10, 10		x		x		x									x									x
Follett																														
DEEP Test of Articulation-	x	x		x	Grades 2 & under	—	x		x								x					x					x			
Stanwix House					3 & under																									
Frostig Devel. Test of Visual Percpt.	x	x	x	x	3-8 yrs.	30-45		x		x		x		x				x				x								x
Consulting Psych.																														
Goldman-Fristoe Test of Artic.-	x	x		x	2 yrs. & over	10	x		x								x					x					x			
American Guidance																														
Goldman-Fristoe-Woodcock Test	x	x		x	4 yrs. & over	15-20		x		x	x										x	x					x			
of Auditory Discrim. -Am. Guid																														
Goodenough-Harris Draw-A-Man	x	x	x		3-5 yrs.	10-15		x		x										x		x								
H B J.																						x								
Harris Test of Lateral Dom.-		x		x	7 yrs. & over	10-15		x	x					x																
Psychological Corp.																														
Lincoln-Oseretsky Tests of	x	x		x	6-14 yrs.	30-60		x		x				x							x	x								
Motor Prof. -Stoelting																														
Peabody Picture Vocab. Test-	x	x		x	2.5-18 yrs.	15-20	x	x		x		x						x			x	x		x						
American Guidance																														
Purdue Perceptual-Motor Survey-	x	x		x	6-10 yrs.	20		x		x		x		x							x	x		x						
Charles E. Merrill																														
Robbins Speech Sound Discrim. &		x		x	4-8 yrs., 8 & over	60	x	x	x			x	x				x					x			x		x			
Verbal Imag. Test-Expression																														
Templin-Darley Tests of Artic.-		x		x	3 yrs., & over	5-15, 20-40	x			x							x				x	x					x			
Bur. of Educ. Resh. & Ser.																														
Wepman Auditory Discrim. Test-	x	x		x	5-9 yrs.	5	x			x	x										x	x					x			
Lang. Resh. Assoc.																														

III

PLACEMENT AND PROGRAM

- IEP DEVELOPMENT AND REVIEW
- LEAST RESTRICTIVE ENVIRONMENT
- SERVICE DELIVERY MODELS
- RELATED SERVICES
- CURRICULUM
- SCHEDULING
- CASELOAD
- DAY CARE CENTERS AND PRESCHOOLS
- PARTIAL LISTS OF SUGGESTED MATERIALS AND CURRICULA

PLACEMENT AND PROGRAM

IEP*DEVELOPMENT AND REVIEW

An Individualized Education Program (IEP) is a written statement for a handicapped child that is developed and implemented to insure that each child is treated as a unique human being and that his/her needs are met individually and separately.

PURPOSE OF THE IEP

1. The IEP meeting serves as a communication vehicle between parents and school personnel and enables them, as equal participants, to jointly determine the child's needs, services to be provided, and anticipated outcomes.
2. The IEP itself serves as the focal point for resolving any differences between the parents and the school, either through the meeting or through the procedural protections that are available to parents.
3. The IEP sets forth in writing a commitment of resources necessary to enable a handicapped child to receive needed special education and related services.
4. The IEP is a management tool that is used to insure that each handicapped child is provided special education and related services appropriate to his/her special learning needs.
5. The IEP is a compliance/monitoring document which may be used by monitoring personnel from each governmental level to determine whether a handicapped child is actually receiving the free appropriate public education agreed to by the parents and the school.
6. The IEP serves as an evaluation device for use in determining the extent of the child's progress toward meeting the projected outcomes. (Note: The law does not require that teachers or other personnel be held accountable if a handicapped child does not achieve the goals and objectives set forth in his/her IEP.)

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*Other terms used to indicate an individual plan include: IHP - Individual Habilitation Plan, ITP - Individual Treatment Plan, ISP - Individual Service Plan, IPP - Individual Program Plan.

COMPONENTS OF AN IEP

Every IEP must contain the following information:

- Present levels of educational performance
- Annual goals
- Short-term objectives
- Specific special education and related services to be provided at center and/or at home (refer to Related Services section, page 43).
- Methods of and timelines for evaluating progress at center and/or at home
- Date the services are to begin and the anticipated duration of services
- Consideration for providing appropriate experiences with nonhandicapped children

The content of an IEP may include goals in such areas as:

- Fine motor development
- Gross motor development
- Receptive language development
- Expressive language development
- Cognitive development
- Self-help skills development
- Social and emotional development
- Individual temperaments and learning styles

IEP COMMITTEE PARTICIPANTS

- Parents/Surrogate/Guardian
- Teacher
- Representative of service provider or agency
- Other individuals at the discretion of parents or service providers (to include evaluation personnel if appropriate)

IEP TIMELINES

The IEP must be finalized prior to placement of the child and the IEP must be in effect before special education and related services are provided to the child.

The above requirement does not preclude temporarily placing a child in a program as part of the evaluation process -- before the IEP is finalized -- to aid in determining the appropriate placement. A preliminary IEP must be developed at the time of enrollment with written parent permission which sets out the specific conditions and timelines for the "preliminary placement" within approximately 30 calendar days of the preliminary placement. The IEP committee must develop a comprehensive IEP which finalizes the placement and outlines services to be provided immediately.

The IEP will be reviewed and revised at least once a year by the IEP committee, or at the time of recommendation for program change. Less formal reviews may be held as frequently as a committee may determine appropriate.

SAMPLE
INDIVIDUALIZED EDUCATION PROGRAM (IEP)

NAME ____________________ DATE OF BIRTH ____________

PARENT(S) NAME ____________________ ADDRESS ____________

TELEPHONE (Home) __________ (Work) __________ FOR EMERGENCIES ____________

PRIMARY LANGUAGE OF CHILD AT HOME __________ CHILD ALLERGIC TO ____________

PRESENT LEVEL OF PERFORMANCE/CHILD'S SKILLS IN FOLLOWING DEVELOPMENTAL AREAS:

DATE OF EVALUATION __________ INSTRUMENT(S) USED ____________

ACADEMICS/COGNITIVE ____________

LANGUAGE/COMMUNICATION ____________

SELF-HELP ____________

SOCIAL/EMOTIONAL ____________

PSYCHOMOTOR/GROSS/FINE-MOTOR ____________

OTHERS ____________

LONG-TERM GOALS: Increase/Decrease Desired Amount Desired Accomplishment Date

1. ____________
2. ____________
3. ____________
4. ____________

(use additional pages as necessary)

SHORT-TERM INSTRUCTIONAL OBJECTIVES: Observable behavior, criterion	Initiation Date	Staff Responsible
for GOAL #1		
for GOAL #2		
for GOAL #3		
for GOAL #4		

NAME______________________________________PRIMARY LANGUAGE OF HOME________________

PERSONS RESPONSIBLE FOR
IMPLEMENTING THIS IEP ____________________ ____________________
(Teacher)

____________________ ____________________ ____________________
(Parent)

RELATED SERVICES PROVIDED: (By whom, how often)

1. ____
2. ____

EXTENT OF PARTICIPATION IN EXPERIENCES WITH NONHANDICAPPED CHILDREN:

Committee Signatures:

TEACHER ____________________ ____________________
Name Title

AGENCY REPRESENTATIVE ____________________ ____________________
Name Title

TEAM MEMBERS ____________________ ____________________
Name Title

____________________ ____________________
Name Title

____________________ ____________________
Name Title

The IEP is not a binding contract. No agency, teacher, or any other person may be held accountable if a child does not achieve growth projected in the objectives.

DATE OF IEP DEVELOPMENT ____________________

I have had the opportunity to participate in the annual development/review of the IEP (Individualized Education Program). I have had my rights and responsibilities explained to me in my primary language. I understand that there will be at least an annual review of my child's progress.

Please check one:

____ I agree with the Individualized Education Program
____ I do not agree with the Individualized Education Program
____ I refuse permission for any Special Education or related services at this time

____________________ ____________________ ________________
Parent/Guardian/Surrogate Date

LEAST RESTRICTIVE ENVIRONMENT

Federal law defines the least restrictive environment as placement in which, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped. For children birth to five years of age, the least restrictive environment is that setting of service delivery and response to individual needs that the IEP committee determines and that maximizes potential for achieving annual goals. Examples of possible settings could include, but are not limited to, those described in the following section.

CONTINUUM OF ALTERNATIVE PLACEMENTS

The idea of a continuum of alternative placements implies that various placement options exist to meet the needs of handicapped children for special education and related services. The following model suggests possible alternative placements for children:

Home based services Family/child instruction in a central location	Move child down as far as necessary. Move back up as child's needs are met.
Regular program with consultant service	
Regular program with modifications	
Regular program with support services	
Integrated classroom	
Self-contained classroom in a neighborhood school	
Self-contained classroom in a special school or center	
Residential early childhood programs	

Home based (which can include a day care center if child is placed there typically during the day) suggests that a team member visit the home to provide training to the parent/family to assist them in meeting the child's needs. This same option could be conducted in a central location, with the parent/family coming to a central location to receive training.

The regular program with consultant services suggests that a consultant or itinerant teacher would work with a teacher (but not directly with the child) to improve service delivery, develop materials, etc.

The regular program with modification suggests that an itinerant consultant and the teacher work together directly with the child.

The regular program with support services implies that a child receives direct services from an itinerant consultant (such as physical therapy, speech therapy).

The integrated classroom is a specially designed early education classroom experience in which identified handicapped children are integrated for education with nonhandicapped children. This may include child care facilities and preschools.

The self-contained classroom in a neighborhood school suggests that handicapped children are educated and receive support services with only handicapped children. Nonhandicapped children are in proximity but are not typically integrated for education purposes.

The self-contained classroom in a special center or school suggests that the child receives services in a location where only handicapped children are located for education and support services.

The residential early childhood program suggests that the child never leaves the facility where he lives for educational purposes.

MAINSTREAMING

Mainstreaming is frequently used as a term to suggest the mixing of handicapped and nonhandicapped children. It may be more precisely defined as the physical integration of handicapped and nonhandicapped children in the same environment. However, mainstreaming does not simply involve enrolling handicapped children in a program with nonhandicapped children. Definite steps must be taken to ensure that handicapped children participate actively and fully in classroom activities. The actual amount of mainstreaming that occurs is dependent upon the individual handicapped child's strengths, weaknesses, and needs. Educators and others must consider the whole child as an individual -- with different needs and abilities and a broad range of behavior and skills. Mainstreaming will also depend upon parents, the staff and resources within a given program, and the resources in the community.

How much mainstreaming occurs is also dependent upon the child's IEP. The principle to follow is that handicapped children should be placed in the least restrictive environment as described earlier in this section.

Mainstreaming involves the efforts of many people working as a team -- teachers, parents and other specialists providing consultant services on a full or part-time basis, agencies serving handicapped children, and the public schools in the community. The operation of an efficient mainstream program often involves additional staff training since the identification, development and coordination of this team effort is both a challenge and a critical requirement in meeting the handicapped child's needs.

The most effective use of resources available can result from carefully conceived interagency agreements aimed at the maximum use of services attainable and the minimum duplication of effort. There is a need to clarify the responsibilities of various agencies, especially in regard to use of their resources to fund appropriate services. (Refer to Chapter VII.)

SERVICE DELIVERY MODELS

Service delivery models are those methods of delivering educational, related service, and/or other intervention services to young children with special needs from birth to five years of age. While a particular means of delivering service may be chosen for a variety of reasons, the model chosen must be directly tied to the IEP, thus establishing the appropriateness of the choice.

MODELS

Service delivery models usually are described as either (1) home based, (2) center based, or (3) home/center based. Each model and subcategories within the models will be described separately in this section.

1. Home Based

   Home is defined as the child's primary residence during the day. This may be the home of his/her parents, a day care facility, a convalescent center, etc.

The home based model is predicated upon the notion that qualified personnel will come to the child's home to provide and/or assist in the provision of services primarily in that environment. In this model, there are usually three possible means of providing service:

- Qualified personnel develop, implement, and evaluate service for the child. Parent or caregiver role is minimal.
- Qualified personnel train parent or caregiver to implement a program developed mutually. Program evaluation is conducted by the qualified personnel.
- Qualified personnel monitor a program developed, implemented, and evaluated by the parent or caregiver. The role of personnel is to assist the parent or caregiver.

2. Center Based*

The center based model is predicated upon the notion that qualified personnel will come to the center or training facility to provide and/or assist in the provision of services primarily in that environment. In this model there are usually three possible means of providing service:

- Qualified personnel develop, implement, and evaluate services for the child.
- Qualified personnel train center staff to implement a program developed mutually. Program evaluation is conducted by the qualified personnel.
- Qualified personnel monitor a program developed, implemented, and evaluated by the staff at the facility. The role of the qualified personnel is to assist the facility staff.

3. Home/Center Based

Program development, implementation, and evaluation are conducted in a combination determined to be appropriate and coordinated by the IEP committee. Qualified personnel, families, and others work cooperatively to meet the child's special needs regardless of the location of the services to be delivered.

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*A center is defined as a training facility or school designed to deal with a child's special needs.

SPECIAL PROBLEMS IN RURAL AREAS

Children with special needs living in remote rural areas often present particularly difficult problems for service delivery. Transportation problems cause the home based model to be the model of choice in rural areas. In rural areas, options could include the home based model as described above or some other options including:

- A mobile van staffed by qualified personnel. The van is really a self-contained classroom and diagnostic facility in which services are provided to the child.
- Telecommunications to deliver information including telephones and satellite-television combinations.
- Video tape recorders (VTR).
- Audio-visual aids such as audio cassette recordings, film strips, super 8 sound loops, slide-tape presentations, and so on.

In addition to these options, families may occasionally come to a central location to receive information or meet with other parents.

Regardless of the options chosen for rural areas, the key remains COMMUNITY INVOLVEMENT. Service providers need to work with all community groups, including church groups, to develop program support, cohesiveness, and coordination.

SPECIAL PROBLEMS IN URBAN AREAS

The programs or combinations of options described in the section on rural areas may be used as appropriate in urban areas. Interagency coordination is frequently a problem in urban areas. (Refer to Chapter VII.)

NATIONALLY VALIDATED MODELS

Certain programs funded by the Office of Special Education's Handicapped Children's Early Education Program (HCEEP) have been validated by the Department of Education's Joint Dissemination and Review Panel. These programs merit some special consideration for program developers. The following matrix describes some of these programs.

RELATED SERVICES

Related or support services are those services which are designed to overcome or ameliorate the child's handicap to enable the child to receive optimal benefit from special education services. The IEP committee shall determine when related services are indicated by the child's needs. Federal law requires that the amount of services to be provided must be stated in the IEP so that the level of the agency's commitment of resources will be clear to parents and other IEP team members. The amount of time to be committed to each of the various services to be provided must be (1) appropriate to the child's needs, and (2) stated in the IEP in a manner that is clear to all who are involved in both the development and implementation of the IEP. The services may be provided as consultation to the personnel and parents working with handicapped children or as direct services to the children enrolled in the program.

If the related services are part of the child's IEP, then the service is to be provided free (at no cost) to the parent.

Related service personnel must possess appropriate state or national certification or licensure relative to professional expertise and/or appropriate training and competencies to deliver the service.

Related services shall include as needed, but shall not be limited to the following:

1. Audiology

   - Identification of children with hearing loss.
   - Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing.
   - Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation.
   - Creation and administration of programs for prevention of hearing loss.
   - Counseling and guidance of pupils, parents, and teachers regarding hearing loss.
   - Determination of the child's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

2. Counseling Services

Services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

3. Early Identification

The implementation of a formal plan for identifying a disability as early as possible in a child's life.

4. Medical Services

Services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services.

5. Occupational Therapy

Improvement in motor function specifically related to daily living and self-care skills.

6. Parent Counseling and Training

Assisting parents in understanding the special needs of their child and providing parents with information about child development.

7. Physical Therapy

Improving motor function in those affected by disease, injury, or developmental disabilities.

8. Psychological Services

- Administering psychological and educational tests, and other assessment procedures.
- Interpreting assessment results.
- Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning.
- Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations.
- Planning and managing a program of psychological services, including psychological counseling for children and parents.

9. Recreation

- Assessment of leisure function.
- Therapeutic recreation services.
- Recreation programs in schools and community agencies.
- Leisure education.

10. School Health Services

Services provided by a qualified school nurse or other qualified person.

11. Social Work Services in Schools

- Preparing a social or developmental history on a handicapped child.
- Group and individual counseling with the child and family.
- Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school.
- Mobilizing school and community resources to enable the child to receive maximum benefit from his or her educational program.

12. Speech Pathology

- Identification of children with speech or language disorders.
- Diagnosis and appraisal of specific speech or language disorders.
- Referral for medical or other professional attention necessary for the habilitation of speech or language disorders.
- Provision of speech and language services for the habilitation or prevention of communicative disorders.
- Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

13. Transportation

- Travel to and from school and between schools.
- Travel in and around school buildings.
- Specialized equipment (such as special or adapted buses, lifts and ramps), if required to provide special transportation for a handicapped child.

CURRICULUM

A curriculum is a wide variety of planned educational experiences based on a particular rationale and designed to help children reach specified goals in the areas of intellectual, physical, social and emotional development. It is especially critical for the curriculum to focus on the totality of the child's developmental experiences. Ideally the curriculum involves not only the child's learning activities in a school setting, but also extends into the home and the community.

CONTENT AREAS

The curriculum of a preschool program for the handicapped is similar to any other preschool curriculum in general goals but should foster development not only by remediating deficient skill areas, but also by improving self-esteem. The curriculum may be unique in that in order to meet the needs of handicapped children it may need to start at a lower developmental level, be far more individualized, and more concentrated on small steps of progress which lead to self-sufficiency.

A basic curriculum might attend to broad content areas such as development of communication skills, motor development, cognitive development, social development, emotional development, self-help skills, and preacademic and perceptual skills as outlined in the IEP. The specific skills which children normally develop during their early years overlap within and between these content areas.

CURRICULUM MODELS

While content areas in an early childhood curriculum for children with special needs may be agreed upon in general, various theoretical approaches may be taken regarding the teaching of these skills. In recent years, a number of models have evolved -- models which vary greatly on many practical and theoretical issues. Some emphasize generally agreed-upon milestones of human growth and development. Others focus on the underlying processes of thinking and cognitive development as described by Jean Piaget. Another approach, sometimes called child-centered, emphasizes the social and emotional development of children in structured environments where "play is the child's work." Another model stresses that all behavior is learned and focuses upon the direct observation, measurement, and reinforcement of behavior.

Comparative studies of various programs and approaches have been done by authorities in the field. The studies, which compared various approaches in terms of effect on I.Q. of participant children, reported little difference in results among the approaches in which there was a strong instructional emphasis. The evidence seems to indicate that any of a number of models, or combined models, will work to benefit children if the teachers are involved and committed, plan intensively within the framework of a proven theoretical model, and are provided with ample supervision and support.

SELECTING A CURRICULUM

The curriculum has the general purpose of focusing the energies of the teaching staff, as well as guiding them in planning their daily instructional lessons. In choosing a curriculum model, one might consider the following:

1. The curriculum's demonstrated effect regarding child progress or changing a child's behavior. (Examine any evaluative data presented by the curriculum developer regarding how effective the curriculum is in helping children obtain educationally relevant goals.)

2. The relationship of the curriculum to the educational and personal philosophies of staff members. (Generally an educational staff will do a better job if they believe in and understand what they are doing.)

3. The curriculum's flexibility in providing success-oriented learning levels. (A child's needs can best be met when the user can adapt the curriculum for children with different learning styles, needs, and rates.)

4. The provision it allows for involving parents in the education of their children. (The research conducted on program success suggests that the most "successful" early intervention programs are those that involve parents in planning and instructing a child at home, and give feedback to parents about the child's progress in the program.)

Finally, regardless of the curriculum chosen, teaching staff must be prepared to adapt materials to the smaller steps and slower progress of handicapped children.

SELECTING INSTRUCTIONAL MATERIALS

When choosing instructional materials for an early education program, three basic criteria should be followed:

1. Materials should fit into the program format and the child's needs rather than causing the program to be built around them.

2. Materials should have multiple uses. Multipurpose toys encourage imaginative play.

3. Materials should be inexpensive, durable and creative.

(Refer to a partial list of suggested curriculums at the end of this chapter.)

SCHEDULING

Early childhood special education programs serve a variety of ages and handicapping conditions. The schedule and length of time a child spends in an educational program should be based on each child's individual needs and capabilities indicated on his Individualized Education Program (IEP). The program recommended by a child's IEP will be determined by the child's health, attention span, strength and level of energy, severity of handicap, and age.

Administrators and teachers need to keep in mind the importance of providing a flexible schedule and alternative programs.

The following are recommendations for planning instruction:

1. The early childhood special education program must be centered around individual instruction of the developmental skills the child is learning and has not yet accomplished. This is not to exclude the importance of reinforcing the child for skills he/she can do successfully. An instructor's time with a child is limited and instructional priorities must be established.

2. Group instruction should take place when two or more children need instruction with the same developmental skills.

3. Parents should be encouraged to take an active role in the education of their child. This could be done by assisting the teacher in identifying which skills should be taught.

TEACHER'S SCHEDULE

Before a final schedule is developed for each child, the early childhood staff should consider the following recommendations:

1. One to two hours a day should be scheduled for preparation, planning, teacher/aide consultation, recordkeeping, etc.

2. At least one-half day a week should be planned for:

   - Consultations with therapists, psychologists, or other supportive staff.
   - Consultations with parents.
   - Advance planning of program activities.
   - Discussions with total staff input on meeting the needs of individual children.
   - Inservice training sessions.
   - Preparation for parental involvement activities.

3. Time should be allowed at the end of the year for the program staff to review the program objectives and note any adjustments which would be helpful for the following year.

4. Time should be allowed at the end of the year for early childhood staff to write an educational evaluation, based on developmental growth and the formal assessments, for each child in the early childhood special education program.

5. Time for travel must be provided for the itinerant teacher who must travel to homes to provide home instruction or who travel to community preschools which may serve handicapped children integrated into their programs with added specialized instruction.

CASELOAD

Nevada Standards for Administration of Special Education Programs suggest caseload limits for preschool classroom programs for those categories of children who may be served in such programs in the State of Nevada. Current _Standards_ may be obtained through the Nevada Department of Education, Special Education Branch. The maximum caseload for professionals in all early childhood service delivery models should include the following considerations:

1. _The child's handicapping condition_. Severely handicapped children need one-to-one instruction. Less severely handicapped children who are developmentally at the same level could be grouped with one instructor.

2. _The age of the child_. Younger children will need one-to-one instruction, and older children could be grouped per instructor.

3. The distance a child lives from the center. In rural areas it may be feasible for a child to travel to the center only one or two days a week even though he/she is five or six years of age.

4. Parental involvement. The amount of parental involvement in a program and the amount of time a parent(s) works consistently with the child may reduce the amount of time a teacher would need direct contact with the child.

5. The availability of aides and volunteers. It is the designing of curriculum and the delineating of objectives which require professional training. The intervention program itself can often be carried out by aides, volunteers or parents who participate in the program.

DAY CARE CENTERS AND PRESCHOOLS

Community day care centers and preschools represent a very important segment of the continuum of services for young handicapped children. There are great benefits to be gained through integration with normally developing children. But not all child care centers feel comfortable or are willing to accept handicapped children who have been identified. Usually the refusal to admit handicapped children occurs because administrators or the staff are fearful and apprehensive about serving handicapped children. They feel they are not trained or able to teach and handle these children and lack both the experience and expertise.

Most of these fears can be overcome through education and training. Caregivers should be provided information about the characteristics of handicapped children and the implications they make for serving these children. The commonalities between handicapped children and all other children should be emphasized, because the goals for educating all children are basically the same. All programs have as their goal to maximize the potential of the children they serve, and all programs should provide environments containing both people and material resources which permit the child to interact at his or her own level of functioning.

Day care centers and preschools may serve several valuable functions in the continuum of services. They may provide routine child care for a child during those times he is not in a special education program. The centers may be used as the most appropriate and least restrictive placement for some handicapped children for their educational programs. The centers may also provide a site for respite care for more severely involved homebound handicapped children.

REQUIREMENTS FOR DAY CARE AND NURSERY SCHOOL LICENSING

Requirements for becoming a licensed child facility are outlined in the Regulations and Standards for Child Care Facilities adopted by the Child Care Services Bureau and promulgated by the Child Care Services Bureau of the Youth Services Division. The standards and regulations provide guidance for:

- Licensure
- Administration of a facility
- Standards for programs
- Discipline of children
- Staffing
- Training
- Staff-to-child ratio
- Health and immunization
- Nutrition
- Staff health
- Consumer health and safety standards
- Preschool requirements

PLACEMENT OF A HANDICAPPED CHILD IN A DAY CARE CENTER

Placement of a handicapped child in a day care center must be recommended by the IEP committee as the most appropriate as well as least restrictive placement. Any day care center which serves handicapped children through an interagency agreement must meet all child care facility standards.

Placement of handicapped children could be made through the development of an interagency agreement (between the preschool and the responsible state or local agency) which provides for inspection of facilities and supervision of the child's educational program. Supervision may be accomplished by an itinerant early childhood special education teacher who also advises on curriculum development, child needs and intervention strategies for the child. The facility must agree to carrying out the appropriate provisions of the IEP.

TRAINING PROGRAM FOR DAY CARE PERSONNEL

Day care personnel in facilities which care for handicapped children should be provided training in both normal and deviant development, characteristics of handicapping conditions, methods for mainstreaming handicapped children, special modifications of materials and activities to accommodate the handicapped, and methods for behavior management and modification.

INTERAGENCY COORDINATION

Coordination and cooperation with responsible state or local agencies to provide services for the handicapped in non-public schools or programs was discussed above. Other facets of interagency cooperation that will greatly further the service to handicapped children include participation with other public and private agencies in preparing or subscribing to early childhood special education newsletters, participation in joint workshops and exchanges of ideas and sharing of methods and materials. (Refer to Chapter VII.)

PROVISION OF ASSISTANCE TO DAY CARE CENTERS

Special education consultants or an itinerant teacher should be made available through the responsible agency to provide advice and assistance to those day care centers that are willing to serve handicapped children in their programs as a part of their normal caseload. When children are placed on an interagency contract, such assistance and supervision should be a part of the agreement.

PARTIAL LIST OF
SUGGESTED MATERIALS AND CURRICULA

Badger, Earladeen. Infant and Toddler Learning Programs. 1971
A developmental curriculum and materials for children from 1 to 36 months stressing sensory motor, language and cognitive development.
Available: Instructo/McGraw Hill
North Cedar Hollow Road
Paoli, Pennsylvania 19301
$100 each for Infant and Toddler Kit

Bricker, Diane and others. Language Training Program for Young Developmentally Delayed Children, Volume 2: Training the Basic Actor-Action-Object Preposition. 1973
A language training program for infants and children, 6 months to 6 years.
Available: IMRID Behavioral Science Monograph #22
George Peabody College for Teachers
Institute on Mental Retardation and Intellectual Development
Nashville, Tennessee 37203
Free (limited availability)

Caldwell, Bettye. Home Teaching Activities. 1971
A series of activities for children from 0-3 to be used by parents to aid in the development of their young children.
Available: Center for Early Development and Education
University of Arkansas
Little Rock, Arkansas 72202
$2.00.

Donahue, Mike and others. Behavioral Development Profile. Manual 1. Parent/Child Home Stimulation "The Marshalltown Project." 1972
A behavioral developmental profile for children 0-6 and a manual for home intervention.
Available: Marshall/Poweshiek Joint County School System
Department of Special Education
Marshalltown, Iowa 50158
Profile $3.00
Manual $6.00

Dybwad, Gunnar. The Mentally Handicapped Child Under Five. 1966
Information and activities to aid in the development of mentally handicapped children 0-5.
Available: National Association for Retarded Citizens
2709 Avenue E East
Arlington, Texas 76011
$.25

Fitzgerald, Hiram E. and others. Orientation Manual for Trainees in Infant Toddler Day Care. 1972
Available: Institute for Family and Child Study
Michigan State University
East Lansing, Michigan 48823
$2.50

Forrestor, Betty and others. Materials for Infant Development. 1971
A discussion of materials that promote infant growth and development.
Available: Demonstration and Research Center for Early Education
John F. Kennedy Center for Research on Education and Human Development
George Peabody College for Teachers
Nashville, Tennessee 37203
$2.00

Furfey, Paul, ed. Education of Children Aged One to Three. 1972
A specific set of techniques for intellectual stimulation of very young children (methods of record keeping discussed).
Available: 1012 14th Street, N.W.
Washington, D.C. 20005
or
Dr. Paul Furfey
School of Education
Curriculum Development Center
Catholic University of America
Washington, D.C. 20017
$2.50

Gordon, Ira J. and others. Child Learning Through Child Play. Learning Activities for Two and Three Year Olds, Games and Activities. 1972
Games and activities for two and three year old children, presented to encourage intellectual and language development.
Available: St. Martin's Press, Inc.
175 Fifth Avenue
New York, New York 10010
$6.95 (cloth)
$3.95 (paperback)

Griswold, Patricia A. A Program Outline for Parents and Their Children, Ages 3 Months to 3 Years, Having Cerebral Palsy. 1972
An outline of activities for parents to use with children who have cerebral palsy.
Available: United Cerebral Palsy of Central Indiana
615 North Alabama Street
Indianapolis, Indiana 46204
$3.00

Groves, Doris and Griffith, Carolyn. Guiding the Development of the Young Visually Handicapped: A Selected List of Activities. 1969
Activities for children 6 months to 10 years who are visually handicapped.
Available: Ohio State School for the Blind
5220 North High Street
Columbus, Ohio 43214
Free

Grunfield, Patricia and Tronick, Edward. Infant Curriculum: The Bromley Health Guide to the Care of Infants. 1973
A curriculum guide focusing on activities to enhance social and cognitive development, planning for individual differences, and working with parents.
Available: Media Projects
201 E. 16th Street
New York, New York 10003
$9.00

Honig, Alice and Lally, Ronald. Infant Caregiving: A Design for Training. 1973
A manual which focuses on the child development aspect of training persons in the care of infants and toddlers.
Available: Media Projects
201 E. 16th Street
New York, New York 10003
$10.95

Hunter, Marvin G. and others. The Retarded Child from Birth to Five: A Multidisciplinary Program for the Child and Family. 1972
Interdisciplinary services for the retarded child aged 0-5 years. The book discusses early identification and treatment of children and it stresses the importance of the parental role and home activities.
Available: John Day Company, Inc.
666 Fifth Avenue
New York, New York 10019
$10.95
(In January, 1975, the John Day Company was sold to the Thomas Y. Crowell Company. Inquiries about John Day publications should be addressed to The Crowell Publishing Corporation at the above address.)

Huntingdon, Dorothy S., ed. Child Development: Day Care. 2. Serving Infants. 1971
Information and principles which can be used in establishing a program for infants and toddlers. Activities are also suggested.
Available: Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402
#1791-0164
$.75

Karnes, Merle. Karnes' Early Language Activities. 1975
Over 1000 activities for children who are functioning developmentally between 18 and 36 months.
Available: Gem
P.O. Box 2339
Station A
Champaign, Illinois 61820
$30.00

Keister, Mary Elizabeth. The Good Life for Infants and Toddlers. 1970
A description of a demonstration center for children 0-3. Essential program elements are discussed such as staff materials and curriculum.
Available: NAEYC (National Association for the Education of Young Children)
1834 Connecticut Avenue
Washington, D.C 20009
$1.50

Koontz, Charles. Koontz Child Developmental Program: Training Activities for the First 48 Months. 1974
An individualized program for evaluating and providing activities for children 1-48 months. Developmental activities for gross motor, fine motor, social, and language are included.
Available: Western Psychological Services
Order Department
12031 Wilshire Boulevard
Los Angeles, California 90005
#W-136
$12.00

Linde, Thomas and Kopp, Thusnelda. Training Retarded Babies and Pre-Schoolers. 1973
Activities for parents, training techniques, and materials to be used by parents to develop skills in the retarded infant and preschool child.
Available: Charles C. Thomas
301-327 Lawrence Avenue
Springfield, Illinois 62717
$12.75

Maternal and Child Health Service. Nutrition and Feeding of Infants and Children Under Three in Group Day Care. 1971
A pamphlet which considers all aspects of infant and toddler nutrition and feeding.
Available: Day Care and Child Development Council of America, Inc.
1012 14th Street, N.W.
Washington, D.C. 20005
$.75

Molloy, Junio S. Teaching the Retarded Child to Talk. 1961
Language development activities for retarded children.
Available: John Day Company
666 Fifth Avenue
New York, New York 10019
$6.95
(In January, 1975, the John Day Company was sold to the Thomas Y. Crowell Company. Inquiries about John Day publications should be addressed to The Crowell Publishing Corporation at the above address.)

Mori, A. and Olive, J. Handbook of Preschool Special Education. 1980
Available: Aspen Systems Corporation
1600 Research Boulevard
Rockville, Maryland 20850
$34.50

Northcott, Winefred. Curriculum Guide: Hearing Impaired Children - Birth to Three Years and Their Parents. 1971
A description of a comprehensive infant program's components for hearing impaired children 0-3 and their parents. The primary focus is on a home centered, parent guided, natural language approach to learning.
Available: Minnesota State Department of Education
Department of Special Education
St. Paul, Minnesota 55101
$6.50

Pizzo, Peggy and Manning, Judy. How Babies Learn to Talk. 1973
A discussion of the importance of talking with babies, language development and the family roles in developing language. The appendix contains summaries of language development research.
Available: Day Care and Child Development Council of America, Inc.
1012 14th Street, N.W.
Washington, D.C. 20005
$2.00

Quick, Alton and others. Memphis Model of Individual Program Planning and Evaluation. A System of Developmental Educational Evaluation and Educational Program Planning for Preschool Age Handicapped Children. 1973
A presentation of the steps to be used in planning for the remediation of developmental deficiencies in preschool aged children.
Available: Memphis State University
Book Store
University Center
Memphis, Tennessee 38152
$4.00

Rabinowitz, Melba. *In the Beginning: A Parent Guide of Activities and Experiences for Infants from Birth to Six Months*. Book 1. 1973
Day by day suggestions for stimulating infants from birth to six months. This workbook is directed toward the non-reader.

Available: Curriculum Specialist
Parent Child Developmental Center
3300 Freret Street
New Orleans, Louisiana 70015
$5.00

Roecker, Vicky L. and others. *Behavioral Prescription Guides. Manual IIA: Communication. Parent Child Home Stimulation "The Marshalltown Project."* 1973
A list of behavioral strategies to aid parents in the prescriptive teaching of their children in the communication area. This guide is intended for use with infants and preschool children.

Available: Marshall-Poweshiek Joint County School System
Department of Special Education
Marshalltown, Iowa 50158
$6.00

Segner, Leslie and Patterson, Charlotte. *Ways to Help Babies Grow and Learn -- Activities for Infant Education*. 1970
Guidelines for developing language, personal-social, fine motor, and gross motor activities for infants.

Available: John F. Kennedy Child Development Center
University of Colorado Medical Center
4200 East 9th Avenue
Denver, Colorado 80220
$3.70

Shearer, David and others. The Portage Guide to Early Education. (experimental edition)
A checklist of behaviors and a card file of curriculum activities for children, aged 0-5.

Available: Portage Project
Cooperative Educational Service
Agency #12
Portage, Wisconsin 53901

each checklist	$.65
card file	$14.50
complete package (file and 10 checklists)	$21.00 + shipping

Smith, Linda and others. Behavioral Prescription Guide. Manual IIC: Social. Parent Child Home Stimulation "The Marshalltown Project." 1973
A guide for parents who are helping their infants and preschool children develop skills in the social area.
Available: Marshall-Poweshiek Joint County School System
Department of Special Education
Marshalltown, Iowa 50158
$6.00

Sparling, Joseph and others. Carolina Infant Curriculum. 1974
An "Infant Development and Education Chart" and "47 Educational Activities" which are products of the Abcedarian Project at the Frank Porter Graham Child Development Center in Chapel Hill, North Carolina. The 47 skills on the chart are correlated with the activities. Each activity is accompanied by a photograph. A variety of additional materials are under development.
Available: Frank Porter Graham Child Development Center
Highway 57 Bypass West
Chapel Hill, North Carolina 27514
$2.00

Taylor, Arlette and Ryan, Margaret. Daily Programming for Infants in Day Care.
Suggestions for arranging learning areas, planning age appropriate activities, handling and caretaking.
Available: Educational Day Care Services Association
11 Day Street
Cambridge, Massachusetts 02140
$1.95 (paper)

Upchurch, Beverly. Easy to Do Toys and Activities for Infants and Toddlers. 1971
A list of recommended toys and activities for infants and toddlers.
Available: Day Care and Child Development Council of America, Inc.
1012 14th Street, N.W.
Washington, D.C. 20005
$1.50

United Cerebral Palsy Association, Inc. The First Three Years: Programming for Atypical Infants and Their Families. 1974
Two sets of manuals which contain technical reports on ways of developing programs for atypical infants and their families. Some of the reports deal with models for staff development, a curriculum guide, parent participation and models of service delivery.
Available: United Cerebral Palsy
66 E. 34th Street
New York, New York 10016
$25.00 (two volumes)

PARTIAL LIST OF
SUGGESTED MATERIALS AND CURRICULA FOR PARENTS

Adair, T. and Eckstein, E. Parents and the Day Care Center. New York: Federation of Protestant Welfare Agencies, 1969.

Parent participation is discussed in terms of parents as "actual and potential assets, capable of helping the center toward a mutual widening of horizons." Attention is given to developing a parent-group profile, a community profile, and channels of communication for more accurate assessment of parental needs for involvement. The last pages are devoted to evaluation questions.

Federation of Protestant Welfare Agencies
281 Park Avenue, South
New York, New York 10010 ($1.65)

Ahr, A. and Simons, B. Parent Handbook: Developing Your Child's Skills and Abilities at Home. Skokie, Illinois: Priority Innovations, Inc., 1968.

A guide for parents who wish to influence their child's behavior so that the child is prepared for school entry. The book contains ideas and activities for working with children in the following areas: comprehension, developing the senses, language, concepts, motor coordination, auditory discrimination, and visual memory.

Priority Innovations, Inc.
P.O. Box 792
Skokie, Illinois 60076 ($2.25)

Auerbach, A. (in cooperation with Child Study Associations of America) Parents Learn Through Group Discussion: Principles and Practices of Parent Group Education. New York: John Wiley and Sons, Inc., 1968.

Details for planning and carrying through continuous small group discussions. This book is mainly for professionals who need guidelines for conducting groups for educating parents about handicapping conditions of children.

John Wiley and Sons
Eastern Distribution Center
1 Wiley Drive
Somerset, New Jersey 08873 ($11.95)

Baldwin, V.; Fredericks, H.D.; and Brodsky, G. Isn't It Time He Outgrew This? or A Training Program for Parents of Retarded Children. Springfield, Illinois: Charles C. Thomas, 1973.

Specific programs for parents who want to develop certain types of behaviors in their retarded child. The parent, without prior training or consultation from professionals, should be able to implement his own specific programs and measure the progress of his child by utilizing the behavior modification techniques and basic learning principles described in this book.

Charles C. Thomas
301-327 East Lawrence Avenue
Springfield, Illinois 62717 ($8.95)

Bauch, J.; Vietze, P.; and Morris, V. "What Makes the Difference in Parental Participation?" *Childhood Education 50* (October 1973): 47-53

A study of data from an Alabama Head Start Project to see which factors most influence the degree of parent participation. According to the study, the most important variable was the size of the center, and the next most important variable was the efforts expended by projects to facilitate participation (i.e., baby-sitting, transportation, etc.)

Childhood Education
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20402 ($2.25 for journal)

Becker, W. *Parents Are Teachers*. Champaign, Illinois: Research Press Company, 1971.

An instructional book on the systematic use of consequences (reinforcers) to teach children in positive ways. The book, which is intended to help parents learn to be more effective teachers, is also useful for staff development and in-service training in behavior management techniques. Ten units with exercises and projects, as well as forms on which to keep records of the target behavior, are included.

Research Press Company
Box 3177
Champaign, Illinois 61820 ($4.00)

Bryan, D. *Guide for Parents of Preschool Visually Handicapped Children*. Springfield, Illinois: Illinois State Office of the Superintendent of Public Distinction, 1969.

An offering of techniques in everyday care for parents of visually handicapped children. This booklet, which is a combination of suggestions from mothers and professionals, discusses parental attitudes and the child's early needs, activities and behavior, and the resources available for help and guidance.

Illinois Office of Education
100 North 1st Street
Springfield, Illinois 62777 (free)

Calvert, D. "Dimensions of Family Involvement in Early Childhood Education." *Exceptional Children 37* (May 1971): 655-659.

A consideration of how best to involve all family members in early intervention programs for handicapped children. In order to plan for maximum benefit, it is urged that the following dimensions be considered: which family members should participate, what should be the nature of their involvement, why should they participate, when should they become involved, and how can their involvement best be secured?

Information Center
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091 (free, one copy)

Clarke-Stewart, K.A. Interactions Between Mothers and Their Young Children: Characteristics and Consequences. Monographs of the Society for Research in Child Development, Vol. 38. Chicago: University of Chicago Press, 1973.

An examination of the relations between behaviors of mothers and children. The author reports that stimulating, responsive mothers influence the child's intellectual development, while in the area of social relations the child's behavior influences the mother's behavior; the implications for mothers' training programs are suggested.

University of Chicago Press
5801 South Ellis Avenue
Chicago, Illinois 60637 ($7.00, issue)

Donahue, M., et al. Parent Discussion Manual. Marshalltown, Iowa: Marshall-Powenshiek Joint County School System, 1973.

A professional guide to a parent education course for mental stimulation of handicapped children. The manual is organized on the basis of the topics of twelve sessions: orientation, responsive program, toys as learning tools, creativity, self-concept, discipline, behavior modification I and II, language, sensory motor development I and II, and open session.

Area Education Agency #6
Preschool Division
507 East Anson
Marshalltown, Iowa 50158 ($6.00)

Exceptional Children. 41 (May 1975).

A special issue titled "The Parent-Professional Partnership" in which all articles pertain to aspects of parent involvement. Articles include the following: "On Being the Parent of a Handicapped Child," "A Lost Generation of Parents," "Matching Families and Services," "Mothers of Retarded Children Review a Parent Education Program," and "The Brain-Damaged Parent (A Parody on Special Services)."

Information Center
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091 (free, one copy)

Galloway, C. and Galloway, K. Parent Groups with a Focus on Precise Behavior Management, II. Nashville, Tennessee: Institute on Mental Retardation and Intellectual Development, Peabody College, 1970.

An exlpanation of procedures for setting up a parent group to instruct parents of retarded children to use the tools of precision teaching in dealing with behavior problems at home. The author examines: strategies for developing parent groups; instruction of parents in the methods of precision teaching; examples of parent projects; and the question "Why do some parents participate and others don't?" This material can be used as a basis for teaching parents how to record baseline data on their child's behavior, intervene, and see if the rate of the behavior changes.

IMRID Publications
George Peabody College
Box 154
Nashville, Tennessee 37203 (free)

Giesy, R., ed. A Guide for Home Visitors. Nashville, Tennessee: DARCEE, George Peabody College, 1970.

A guide developed for use with paraprofessionals in the homes of low-income children, which provides information for persons who are training to be home visitors. Topics discussed include: introduction to the home visiting approach, living conditions that influence learning, how home visiting is done. and recording home visits. The appendix includes suggested activities for home visits, and a sample unit.

DARCEE
Publication Office
George Peabody College
Nashville, Tennessee 37203 ($4.50)

Gordon, T. Parent Effectiveness Training: The "No-Lose" Program for Raising Responsible Children. New York: Peter W. Wyden, Inc., 1971.

A description of a complete model for effective parent-child relationships. Discusses such areas as: parents as persons, active listening, putting "I-messages" to work, parental power, "no-lose" method to solve conflicts, and exercises to facilitate using the model.

David McKay Company
750 Third Avenue
New York, New York 10017 ($10.95)

Gray, S. "The Child's First Teacher." Childhood Education 48 (1971): 127-129.

A description of the philosophy (working with the mother) behind the programs of the Demonstration and Research Center for Early Education, as well as an examination of the reasons for the success of the home visitor programs.

Childhood Education
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20402 ($1.75, issue)

Green, J.S. Parent Education Handbook. Chattanooga, Tennessee: Tennessee Re-Education Program, Tennessee Department of Mental Health, Children's Re-Education Center, undated.

A guide based on Gordon's Parent Effectiveness Training for individuals who are interested in offering courses in parent education; discusses functions of group leader; structure of the parent group; areas for group discussion such as defining behaviors; contracting, punishment; teaching responsibility; and communications in the family.

Small Wood's School
Moccasin Bend Road
Chattanogga, Tennessee 37405 (free)

Harms, T. and Smith, J. Changes in Parent/Teacher Expectations in Cooperative Preschools. Urbana, Illinois: University of Illinois, 1975.

A discussion of the sources of conflict in parent cooperatives and suggested ways to help resolve some of the conflicts.

Publications Office
College of Education, University of Illinois
805 West Pennsylvania Avenue
Urbana, Illinois 61801 ($1.50)

Honig, A. Parent Involvement in Early Childhood Education. Washington: National Association for the Education of Young Children, 1974.

An up-to-date account of the varieties of programs which are oriented toward family involvement. Contents include: research, rights of parents, ways to increase sensitivity and skills, and an extensive list of current resources and materials.

National Association for the Education of Young Children
1834 Connecticut Avenue, N.W.
Washington, D.C. 20009 ($3.00)

Jew, W. "Helping Handicapped Infants and Their Families: The Delayed Development Project." Children Today 3 (May-June 1974): 7-13.

A description of the Delayed Development Project, a program that serves children from birth through the age of three in San Joaquin County, California. Contains information on parent involvement, community involvement, and project evaluation.

U.S. Government Printing Office
Washington, D.C. 20402 ($1.25, single issue)

Karnes, M. and Zehrbach, R. "Flexibility in Getting Parents Involved in the School." Teaching Exceptional Children 5 (Fall 1972): 6-19.

A description of a variety of strategies and techniques to meet the multiple goals of each family in a parent program, based on a needs assessment in helping parents select the desired type of involvement. Within each strategy, consideration is given to application, misapplication, advantages and disadvantages.

Colonel Wolfe School
403 East Healey Street
Champaign, Illinois 61820 (free)

Noland, R., ed. Counseling Parents of the Mentally Retarded: A Sourcebook. Springfield, Illinois: Charles C. Thomas, 1970.

A collection of articles dealing with aspects of parent counseling. The overview in the book deals with parental feelings and attitudes; part two deals with initial counseling needs for parents who have learned of their child's deficiency; part three discusses the group counseling process, for both orientation and therapeutic purposes; and other parts deal with parental and genetic counseling. The book's appendices list parents' associations, clinical programs, and audiovisual materials.

Charles C. Thomas
301-327 East Lawrence Avenue
Springfield, Illinois 62717 ($9.75)

Northcott, W. Curriculum Guide: Hearing-Impaired Children--Birth to Three Years--and Their Parents. St. Paul: Minnesota State Department of Education, 1971.

A description of the components of a comprehensive infant program which focuses on a home-centered, parent-guided, natural language approach to learning based on the child's daily activities. The book provides guidelines for the development of the infant program, parent guidance and education, principles of language development, and parent-child interaction problems. Includes program objectives for parent and child and suggested daily home activities, as well as experience charts and auditory training exercises.

Minnesota State Department of Education
Department of Special Education
St. Paul, Minnesota 55101 ($6.50)

Northcott, W. "Parenting a Hearing-Impaired Child." Hearing and Speech News 41 (September-October 1973): 10-12, 28-29.

A description of a systems approach to parent participation in a program for ninety-six children under three years of age in the Minneapolis public schools. The program features information exchange, the facilitation of growth in parents through opportunities to practice child management, and the establishment of trust between parents and the teacher. Discusses various aids for parents, such as weekly visits, meetings for fathers only, mothers, and siblings.

NAHSA
814 Thayer Avenue
Silver Springs, Maryland 20910 ($.20)

Patterson, G.R. and Gullion, M.E. Living with Children: New Methods for Parents and Teachers. Champaign, Illinois: Research Press, 1978.

A detailed explanation of the manner in which the parent teaches the child and the child teaches the parent. The first section deals with how parents and children learn and it discusses reinforcers, accidental training, and retraining. The second section deals with changing undesirable behavior, such as in a child who fights too often; in an overly active child; or in a dependent, frightened, or withdrawn child.

Research Press
P.O. Box 3377
Country Fair Station
Champaign, Illinois ($3.50)

IV

PERSONNEL

- FAMILY INVOLVEMENT
- TEACHER COMPETENCIES
- USING AIDES AND VOLUNTEERS

PERSONNEL

FAMILY INVOLVEMENT

The impact of the home environment is extremely significant for the development of a young child. Parents are the primary teachers of their children. Any intervention relevant to the special needs of a young child has the potential of being more effective if family members are actively involved in that intervention. Children are primarily the responsibility of parents. Professionals may provide assistance to parents to become more effective parents and learn how to deal with special needs as those arise.

RATIONALE FOR FAMILY INVOLVEMENT

The rationale for working with families in an early childhood special education program might best be stated in terms of its benefits for the child, the family, the program, and the community. A family program offers the following benefits:

1. Acknowledges Parents' Right to be Involved.

   Parents are responsible for fostering and monitoring their child's training and development throughout the formative years. If parents are to be held accountable, their involvement must be given support. Their rights to be knowledgeable participants and have access to their children's records has been reinforced by federal laws. The recent rise in consumerism also dictates that the parent-consumers become participants in all levels of the educational/training experience they seek for their child.

2. Enables the Staff to Recognize the Child as Part of a Dynamic Family Unit.

   The child experiences the family impact as ever present and frequently changing. As a staff comes to know the family through various contacts, it is better equipped to understand the individual circumstances and resources that affect the child and the family.

3. Provides for Greater Continuity and Coordination in the Child's Training.

   When both parents and staff plan goals and training techniques, the child is exposed to a continuity and consistency that will foster learning and emotional stability.

4. Facilitates Individual Programs for the Child and Parents.

Parents know their child better than anyone else. The more they and the staff exchange information about him, the more readily appropriate objectives can be developed for each child. As the staff gets to know each set of parents, it will become more effective in helping each family use its own assets to meet its needs.

5. Teaches Family Members About Child Development and Gives Them Specific Skills.

As parents learn more about child development and are better able to deal with their child, they feel more adequate as parents. Once they begin to focus on their child's accomplishments rather than on his or her handicap, they may see both themselves and their child more positively. When parents feel adequate and are able to take pride in their child's progress, they often experience some relief from the despair that is so frequently present in parents of the handicapped.

6. Forms a Supportive Community for the Families of Handicapped Children.

The chronic sorrow, stress, and the daily challenge of caring for a handicapped child are experiences that families can share most meaningfully with each other. The emotional support they give each other can be strengthened by learning, socializing, and working together. This benefit is often overlooked by professionals who feel they should have all the answers. Often one parent can give, better than anyone else, the support and practical advice that another parent needs.

7. Maintains a Program Relevant to the Needs of the Families and the Community.

As parents talk about a program for their own child, the alert director or staff member will recognize their needs and expectations and will try to help meet these needs with either the center's program or other community resources. Parents can also help the program maintain relevance and consumer satisfaction by participating on boards, committees or councils that determine its policy and programs.

8. Helps Families Use and Develop Other Community Resources as Needed.

Since the early childhood special education program may be the agency with which the family has the most continuous contact, other family needs will often become known to the staff. Though many of these needs do not fall in the range of services offered by the program, appropriate referrals and follow-up can minimize the all too frequent fragmentation of services. Often when needs for which services do not exist are recognized, staff and parents become advocates within the community to develop services or new agencies to meet the needs.

9. Builds a Base of Community Knowledge and Support for the Program.

Advocacy is often overlooked by conscientious professionals who feel that it is sufficient to do a good job. If the care and training of handicapped children is a needed service in the community, the program will continue to require knowledgeable advocates to go before decision makers and elected officials and to participate in local fund-raising. Enthusiastic parents who know what you are doing can be the most effective spokesmen for the program. Politicians hear their voters, especially if they are consumers of the services sought or long-time friends of the community. (Adapted from Working With Families, Chapel Hill Training-Outreach Project, 1975, pp. 7-8.)

NATURE OF FAMILY INVOLVEMENT

Family participation in early intervention programs varies greatly from no responsibility at all to very intense responsibility for the program planning, implementation, and its development in general. Some of the roles parents have assumed in various programs nationwide are:

- Observation of their own and other children in the center.
- Recording data, under teacher direction, related to the observed behavior of their own child at center and at home.
- Attending parents' meetings.
- Participating in training workshops and conferences.
- Attending orientation meetings for new parents.
- Participating as a member of program's home visitation team.
- Working in classroom as teacher's assistant.
- Editing newsletters for families.
- Disseminating program-related information in the community.

- Organizing "Open Houses" for the program.
- Participating on program advisory committee.
- Participating in child advocacy group.
- Learning therapeutic techniques to remediate problems.
- Learning to cope with their feelings.
- Learning to acknowledge rights of siblings in the family.

TEACHER COMPETENCIES*

Listed below are competencies categorized according to the identified dimensions which are considered most crucial in the field of early childhood special education. However, it is understood that the sophistication level of the training and qualifications of staff will vary according to the criteria and standards of individual programs and agencies providing services to young handicapped children. For example, Head Start programs, child care centers and respite care programs will probably rely more on training procedures provided by Child Development Associates (CDA) or any other similar system for hiring and training their staff. School districts and other state and private agencies will probably require university or community college graduates. It is anticipated that individuals with training in a) child development from a home economics college, b) regular early childhood education, and/or c) special education with additional early childhood inservice and/or preservice training may develop the competencies to work with young handicapped children.

CHILD-RELATED COMPETENCIES

1. Knowledge of child development and developmental guidelines in areas such as:
    - Fine motor development
    - Gross motor development
    - Receptive language development
    - Expressive language development
    - Cognitive development
    - Self-help skills development

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*Adapted from a chapter in the book Early Childhood Education for the Handicapped by Nasim Dil, Ph.D.

- Social and emotional development
- Individual temperament and learning styles of young children

2. Knowledge of developmental disorders and delays such as:
   - Physical disorders: prenatal, perinatal and postnatal
   - Sensory deficits
   - Delayed language and communication disorders
   - Learning and cognitive problems
   - Behavior disorders (social and emotional)
   - Perceptual/motor disorders
3. Demonstrated performance in working individually and in small and large groups of handicapped children with varying disabilities between the ages of:
   - Birth to 18 months
   - 18 months to 3 years
   - 3 to 5 years
4. Demonstrated performance in providing a physically safe and healthy learning environment for children.
5. Demonstrated performance in providing continuity of services for children between home and center.

FAMILY-RELATED COMPETENCIES

1. Knowledge of average family dynamics:
   - Values, philosophy of life, etc.
   - Interrelationships
   - Roles
   - Expectations
   - Conflicts
   - Aspirations

2. Knowledge of families with handicapped children:
   - Impact of a handicapped child on family dynamics
   - Impact of family dynamics on handicapped child
   - Affective processes, adaptations, etc.
   - Individual coping styles

3. Knowledge of impact of specific handicapping conditions on families, i.e., individual differences of families with children who are blind, deaf, mentally retarded, emotionally disturbed, etc.

4. Demonstrated performance in working with families of handicapped children in an accepting and non-threatening manner.

5. Demonstrated performance in assisting families to work cooperatively with professionals.

6. Demonstrated performance in assisting families to become more effective with their own children.

7. Demonstrated performance in teaching parents about the rights of parents and children.

ASSESSMENT-RELATED COMPETENCIES

1. Critical knowledge of standardized tests used for the assessment of children from:
   - Birth to 3 years
   - 3 to 5 years

2. Knowledge of objective versus subjective assessment.

3. Knowledge of observation techniques for ongoing and periodic assessment.

4. Ability to utilize cumulative records of children to write goals and objectives appropriate to the current functioning level of children.

5. Ability to assess the current functioning level of children by utilizing appropriate checklists and relevant assessment instruments.

CURRICULUM-RELATED COMPETENCIES

1. Critical knowledge of the commercial curricula available for children between the ages of:

    - Birth to 18 months

    - 18 months to 3 years

    - 3 to 5 years

2. Ability to select the best of curriculum/set of curricula most appropriate for the children under consideration for intervention.

3. Ability to modify, adapt or develop curriculum/curricula suited to the individual needs of children.

4. Ability to utilize curriculum/curricula for writing IEPs, long-range and short-range objectives for individual children.

TEACHING-RELATED COMPETENCIES

1. Planning for teaching:

    - Ability to write goals, long-range and short-range objectives for individual children

    - Ability to plan lessons for individuals, small and large groups of children

    - Ability to explore or develop materials suited to the planned lessons

    - Ability to organize and reorganize the learning environment according to each lesson plan and individual needs of children

    - Ability to group and regroup children appropriate to individual needs and varying activities

    - Ability to coordinate support staff (teacher assistants, volunteers, parents and others) to individualize instruction

    - Ability to design evaluation procedures to test the effectiveness of teaching

    - Explicit knowledge of personal philosophy of teaching and learning as it relates to young handicapped children and their families

2. Implementation of teaching plans:

   - Ability to relate with individual children
   - Ability to teach children individually, in small and large groups
   - Ability to seek and maintain the attention and interest of children for the duration of the teaching activity
   - Ability to ask questions, prompt or probe according to the individual levels of children
   - Ability to provide appropriate reinforcement individually
   - Flexibility to make modifications in lesson plans spontaneously according to the circumstances

3. Evaluation of teaching:

   - Ability to make modifications in the teaching process based on the feedback from children's learning, self, peers, parents and/or supervisor

FIELD-RELATED COMPETENCIES

1. Knowledge of the general field of Early Childhood Special Education (ECSE).
2. Rationale for ECSE.
3. Legislation related to ECSE.
4. Knowledge of various models appropriate for providing services to young handicapped children.
5. Knowledge of current and future trends (local, state and national) in ECSE.
6. Knowledge of some successful and effective programs in ECSE

COMMUNITY-RELATED COMPETENCIES

1. Knowledge of related human and material resources, other agencies, etc. in the community.
2. Ability to utilize available resources for the maximum benefit of children and families.
3. Ability to advocate for the needed resources which are not available in the community.

PERSONALITY-RELATED COMPETENCIES

1. Perceptiveness and sensitivity to individual differences.
2. Ability to communicate with children and parents in an accepting and non-threatening manner.
3. Ability to relate with other professionals.
4. Ability to listen in a non-judgmental manner.
5. Ability to focus on positives.
6. Positive attitude toward differences.
7. Self-confidence.

USING AIDES AND VOLUNTEERS IN THE PROGRAM

Aides and volunteers can be tremendous assets to a good early childhood special education program. There may never be sufficient resources to provide the program intensity that may be desirable or necessary for younger and more severely handicapped children without paraprofessional or volunteer assistance.

DESIRABLE QUALITIES FOR AIDES AND VOLUNTEERS

1. Competency in using appropriate language patterns.
2. Desire to work with children.
3. Patience and tolerance.
4. Willingness to accept responsibility.
5. Honesty, integrity, and sincerity.
6. Cooperativeness.
7. Respect for individual differences and personal worth.
8. Appropriate manner of dress and general personal neatness.
9. Ability to work with a teacher-supervisor.
10. Ability to work with various school personnel.
11. Ability to maintain confidentiality.

RESPONSIBILITIES OF AIDES

Program administration should establish general policies and guidelines for determining the functions to be performed by teacher aides. The aide will be involved in noninstructional and instructional-related tasks. Under supervision of the teacher, he/she will assist in providing an environment in which children can work and play comfortably. The aide will provide close personal support as well as instructional support to the children. Under the guidance of the teacher, the aide may carry out responsibilities similar to the following:

1. Prepare instructional materials.
2. Assist children with projects and activities.
3. Organize instructional materials important to the classroom operation.
4. Arrange physical environment in which children play and work.
5. Arrange materials for accessibility.
6. Check ventilation and lighting.
7. Assist in hygiene care of non-toilet trained children.
8. Help children develop good eating habits by sitting at tables during snack and mealtime, conversing with children, and encouraging good table manners.
9. Encourage habits of safety in handling materials for work and play.
10. Help children gain independence in getting, using and putting away materials.
11. Assist children as new materials are introduced.
12. Assist in supervising outdoor and indoor play activities, walking tours and field trips.
13. Assist in activities planned with and for parents.
14. Work with individual child or small group.
15. Help with outdoor clothing.
16. Help with transportation.
17. Check on health and assist with health or hygiene projects.

TRAINING AIDES AND VOLUNTEERS

Every new employee must be given an orientation program and trained in the policies, procedures and program of the facility and the recognition of symptoms of illness. Aides and volunteers who assist in early childhood special education programs should be provided training which will make them more effective adults in working with handicapped children. Areas of training might include the following:

- Intellectual development
- Emotional development and behavior
- Speech and language development
- Developing and learning
- Motor disabilities
- Intellectual disabilities
- Visual disabilities
- Learning disabilities
- Hearing disabilities
- Language disabilities
- Emotional and behavioral disabilities

WORKING WITH AIDES AND VOLUNTEERS

Taking time to orient and communicate expectations will greatly increase the chances that an assistant's participation will be both enjoyable and productive. Techniques for ensuring good working relations include:

1. Orientation to the school, the staff, and the program.

   Because aides and volunteers may be new to the school or center, it will be necessary to spend some time orienting them to policies, procedures, and protocol. It may be helpful to provide:

   - A list of staff members, their classrooms, and teaching assignments
   - A list of students who will be served in the program
   - Written information describing, or a thorough verbal explanation of local policies for issues like confi-

dentiality, professional responsibility, entering/leaving the building during other than regular hours, etc.

2. Explanation of tasks expected of him/her.

   Make certain the assistant knows a) what to do, and b) how to do it.

   One strategy would be to list the tasks the person is expected to accomplish daily and weekly. Then, spend some time reviewing the list with the aide, explaining in detail exactly what is expected.

   Although thorough explanations and written notes or lists are helpful, actually demonstrating (modeling) is one of the most effective ways of communicating what should be done. It may be helpful to "walk through" some of the tasks with the person responsible for accomplishing them.

3. Correcting problems of communication with assistants.

   Personal discussion of problems encountered in working with paraprofessionals seems to be one of the most effective ways of turning unsuccessful situations into successful ones.

   The following tips are offered as tactics to try in talking through existing problems:

   - Try to talk early, rather than to let a small problem develop into a major disaster.
   - Try to enter the discussion willing to share responsibility for what has happened or not happened, rather than blaming the other person.
   - Try to determine if the problem is most closely related to someone:
     a. not knowing what to do (a clarification of expected performance may solve the problem)
     b. not knowing how to do what is expected (a little direct teaching may go a long way)
     c. not wanting to do something, or feeling that the task assigned is not worth doing (it may be necessary to change the task itself, or change the consequences for doing the task)

- Try to focus on what can be done rather than what has already occurred (remember, there is still a chance to set up success in the future).

- Try to generate several alternative solutions or next steps, in order to choose what appears to be the highest probability-for-success choice. Set a date for touching base again to see how things are going.

V

PROGRAM ENVIRONMENT

- FACILITIES
- ADAPTING THE ENVIRONMENT
- PLANNING THE ENVIRONMENT
- LEARNING CENTERS
- SAFETY
- HEALTH

PROGRAM ENVIRONMENT

In programs for handicapped children, the environment needs special attention. The environment -- the inside and outside spaces of the center or home and the materials and equipment in those spaces -- sets the stage for learning. A well-planned environment helps to facilitate teaching and eases the workload. A clearly arranged environment can do a great deal to reduce behavior problems and increase children's independence. An organized environment can save time cleaning up during the day, hunting for lost items, and maintaining order. Planning space will minimize the potential for crowding and confusion. Good arrangements of learning centers and materials will prevent unnecessary movement of furniture and materials.

A meaningful organization of materials, furniture, activities and space will invite children to learn and play. A well-planned environment helps children develop independence and feel rewarded through self-directed activities. In addition, the careful planning of room arrangement offers a sense of security and order, needed by handicapped children.

FACILITIES

When planning a new early childhood special education program, one needs to consider the facilities which would include site and grounds, buildings, and equipment.

1. There should be a safe area for the children to be brought into or picked up from the school.

2. Office space should be provided for teacher(s) and aide(s) planning and staffing activities.

3. There should be a bathroom for adults and visitors and one for children. The bathroom should be near the classroom and children should not have to go up and down stairs.

4. There should be a work sink or sinks in or near the classroom with hot and cold water at a convenient height for the children.

5. Physical facilities should be equal or better than those to house regular education classes, large enough to accommodate and store special equipment and materials, and adequate for small group sessions.

6. Building and facility standards regarding child care facilities have been developed by the Child Care Services Bureau, Youth Services Division, of the State of Nevada. Minimum space requirements are set forth in those regulations. The following aspects should be considered:

    - A facility should contain at least 35 square feet of indoor space for each child, exclusive of bathrooms, halls, kitchen, stairs, and storage spaces.

    - A facility should contain at least 37-1/2 square feet of outdoor play space for each child, as determined by the maximum number of children stated on the license for the facility. The play area must be fenced or enclosed in a manner that prevents unsupervised departure of children from the area and must be free of hazards, debris and trash. Every outdoor play area must contain trees or a structure which is capable of providing adequate shade for the children using the area.

ADAPTING THE ENVIRONMENT

Both handicapped children and adults must be able to enter the facility and move around with ease. A facility may need to be adapted or modified for accessibility.

There are some general considerations and adaptations which will help prevent accidents to handicapped children. Such modifications do not involve moving walls or permanent fixtures. Many can be made at minimum cost.

1. Entrance ramps. If the building is not at ground level, entrance ramps are needed for persons in wheelchairs, those who use crutches or leg braces, or who have motor problems, as well as for visually impaired children. Ramps should be 36 inches wide and have a slight, gentle slope. An inexpensive ramp can be made from heavy plywood.

2. Door openings. Door openings should be wide enough to accommodate all types of wheelchairs and be in compliance with local regulations.

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3. Door thresholds. For children with motor problems or visual handicaps, door thresholds can present problems. Thresholds should not be more than 3/4-inch high. If there is carpeting between rooms, be sure it is nailed securely in place so children will not trip.

4. Floors. Floor and stair coverings should be of non-slip material. Tile floor coverings in rooms or hallways should not be heavily waxed and slippery. Carpeting should be used for those areas in which children play or sit on the floor.

5. Stairs. If there are stairs which children must climb, they should be enclosed and should not have an extended edge over which a child might trip.

6. Diapering areas. Special screened-off areas in the classroom or activity areas should be provided if there are children whose diapers must be changed during their time at the facility.

In all centers, there are several features that can be easily adapted for use by handicapped children. Important adaptations can be made which relate to storing personal belongings and toileting. Other changes can easily be made regarding floor surfaces, lighting and walls:

1. Storage. Each child needs separate space for storing personal belongings. He/she needs a place to hang a coat, put papers to take home, and lunch sacks if lunch is not provided. Avoid using metal lockers. They are difficult for young children to use, have sharp edges, and clang and bang. One good solution is to attach large hooks to the wall. Shelves or rubber dish pans can be placed on the floor under the hooks to store things. Orthopedically handicapped children can hang their sweaters on the small lower portion of the hook and their adaptive devices on the large upper portion.

2. Toilets. Potty chairs are best for very young children. Standard toilets will have to be adapted for handicapped children. Children need to be able to get onto the toilet without assistance, and they need help knowing where to place their feet. The oval openings in standard toilets need to be made smaller. When these changes are made, children may be taught to use the toilets by themselves.

   Wooden cola boxes or specially made wooden steps should be available for assisting children in using the standard toilet. Be sure the top step is large enough for children to turn around on and high enough so the children's feet can rest on it. Tape two clearly defined toe and heel marks on the top step. Toe marks show boys who have learned to stand while toileting to know where to put their toes. Heel marks show both boys and girls where to place their heels while seated. Use plastic toilet seat adapters (which can be purchased) or smooth boards which are firmly secured to make the large oval openings in the toilets smaller. Place a gallon-size container next to the toilet or use brackets attached to the wall to hold crutches or other special equipment.

3. Lighting. Shades or blinds will help to adjust natural lighting. Fluorescent lighting or bulb lights need to be glare-free. Visually handicapped children may require additional lighting to meet their needs. Remember that light-colored walls increase the amount of light available in a room.

   Make sure that electrical cords are in good repair and out of the path of children. Reduce the light for children whose eyes are light sensitive. Obtain an additional lamp to increase lighting for children who need more light for close work.

4. Walls. Walls can be used for hanging such things as children's art work and photographs. Be sure all wall displays are at the children's eye level. Sometimes, the walls in centers are made of concrete blocks. These walls are extremely difficult to hang things from. Hooks can be glued on these walls to hold art work, etc. Inexpensive vine hooks can be purchased in a kit with glue at plant nurseries. They are normally used to train vines on the outside of a house. They will hold a lot of weight, and if the hook does give way, there are no sharp edges.

PLANNING THE ENVIRONMENT

The height of the ceiling, the shape of your classroom, the number of windows, outlets, etc. may not be possible to change. However, one can still have the freedom to arrange the furniture and equipment within the space. In organizing the space in the classroom, consider the following:

1. Make sure there are areas set up for the types of activities to be conducted:

- Are there spaces for small group activities, where students can go to work independently, for storing instructional materials and supplies, for free time areas or interest centers, for audio-visual equipment (tape recorders, language masters, etc.)?

- Are there areas designated for motor and self-care skills?

- Is there a designated quiet area?

- Are there provisions for observation of a child by a parent or teacher without interrupting instruction?

2. Make certain students and teachers can move freely and easily in and out, and around the classroom:

   - Is the classroom accessible to students in wheelchairs?

   - Is there enough space for unencumbered traffic flow into and out of the classroom?

   - Is there adequate space for students and teachers to move from one area to another without bothering others?

3. Arrange things so the classroom is manageable, both for staff and students:

   - Are all areas of the classroom visually accessible, i.e., do dividers separate areas, yet not block vision?

   - Are supplies stored in places where students can get needed materials easily?

   - Are areas designated for storing individual student work packets, for work which needs correcting, etc.?

   - Is the classroom arranged so that furniture need not be moved during the day?

4. Make the environment attractive and comfortable:

   - Have colors been used to help divide space, or to connect one area with another?

   - Are working areas comfortable, i.e., have they adequate light, comfortable temperature, etc.?

   - Are there spaces which provide alternative environments, i.e., tables and chairs, rugs and cushions, etc.?

LEARNING CENTERS

Learning centers are effective tools in instructional planning for handicapped as well as nonhandicapped children. They help give handicapped children the individual attention they need and enable them to work independently. Learning centers will also provide areas for nonhandicapped children to use independently while the teacher works with the handicapped child. Extra space may be needed in learning centers for children who use walkers or those who are confined to a wheelchair.

Learning centers help children to:

- focus attention on activities and learning
- organize their space and actions
- associate activities and equipment
- categorize materials
- use work space independently
- care for and clean up materials

Each learning center or work area should have available a special set of materials and work opportunities daily for children. Types of learning centers can include:

- dramatic play or homemaking area
- book area
- manipulative area
- block building or construction area
- art area
- science area
- music area
- area for motor or movement activities
- water area

ADAPTING AND PLANNING A LEARNING CENTER

It may be appropriate to adapt the learning center to the needs of the child rather than making the child change. Usually, adaptations can be made easily and with little or no expense. Before making any adaptations or additions to learning centers and center activities, consider the age of the handicapped child, the child's handicapping problems and special equipment the child may need because of special conditions, the number of children that will be using the center together, and the activities that are planned in the child's individual program. Then necessary adaptations or purchases can be made knowing that they will be right for the child. Consider the following adaptations:

- Place quiet areas as far away from noisy areas (homemaking, blocks, etc.) and traffic patterns as possible. Consider locating them in corners of the room. The two walls which form the corner will absorb sound. Visual distractions are reduced by the walls. Seating the children with their backs to the rest of the room will also reduce distractions and allow staff to watch other children in the room while working individually with the handicapped child or children. A portable table and floor carrels made from cardboard can also be used to eliminate distraction.

- If a child has difficulty doing an activity, moving within the space of a learning center, or using the total space of the center, certain changes may be necessary. Many times, simple adaptations are enough to help special children use the space, the furniture and the materials.

- Careful planning, organizing and adapting the specific types of materials and activities that go on in learning centers is essential. In the art area, large-handled pencils, crayons and brushes for children with small muscle coordination problems may be needed. Easy-grip scissors will make cutting activities easier for them, too.

- In the dramatic play area, set up hooks to hang dress-up clothes rather than folding them in a box. It is best to have more large utensils than small. Real utensils, tools, and objects work best with some handicapped children.

- For table activities, preschool chairs are usually ordered in one size. Children come in many sizes. Some children have to dangle their feetin preschool-size chairs. It is important for posture and circulation to keep the knees above the hips.

- Children whose legs dangle will need their chairs adapted. A box stuffed with phone books can be used as a footrest to the chair. The height of the box will depend on the size of the child. Children who wear leg braces benefit from this adaptation, because it prevents poor circulation of their legs. Or, use a weighted box as a footrest if a chair is too large for a child.

- Add handles or knobs to materials that are difficult to grasp. For example, a puzzle can be adapted by gluing a small empty thread spool to each puzzle piece.

- Use rubber padding under materials that slide easily. This will hold the activity firmly so that a child can work without having to concentrate on keeping materials in place.

- Sometimes children with motor problems have a difficult time using their hands. They must concentrate very hard in order to coordinate hand movements. Place fine motor activities in a quiet area with few distractions.

- Structure activities with boundaries. Make sure that all the materials a child needs are included in the activity containers. This encourages independence and self-organization. Structured activities that they can work independently help children learn that they are competent.

- Use a special texture to indicate ownership. A nubby material swatch on the storage cubicle, on the chair in the manipulative area, and on the activity the visually impaired child is working with that day, helps this child locate the activity.

- Make a table easel for table games. Looking at books or some art activities is easier on an easel also. Children with low vision often need to get very close to their work. This is hard on posture. A table easel raises the work so that the children can maintain posture.

- Enlarge teaching pictures. Children with low vision enjoy looking at pictures. But sometimes, the pictures need to be enlarged. Using an overhead, slide or opaque projector helps these children see pictures. Plan to keep one wall blank, or place hooks across a wall area so that a sheet can be easily and quickly hung as a screen.

- Some children continually disrupt the circle or storytime by changing place, or bouncing up and down. Such children may need a boundary for their body. Use a carpet square to mark the child's seat or taped circle boundaries to help active children know where they are supposed to be in large group activities.

SAFETY

It is the intent of this section to remind educators that safety standards are important and must be reinforced in an early childhood program. Young children are curious and full of energy; therefore, teachers and aides must make children aware of rules in the classroom and on the playground. All materials and equipment should be kept in good condition, and all hazardous obstacles should be removed.

FIRE AND SAFETY REGULATIONS

Fire and safety regulations are provided in a summary format in the *Regulations and Standards for Child Care Facilities* distributed by the Child Care Services - Bureau of the Nevada Youth Services Division. Be advised that child care facilities must comply with local fire and safety regulations, which may in some cases vary slightly.

SAFETY PRECAUTIONS

Gates, windows, doors:

- Use safety gates to keep children in safe areas.
- Keep doors leading to stairways, driveways, and storage areas securely fastened.
- Use window guards or open windows from top only.
- Keep screens locked and nailed.
- Any pieces of furniture on which child could climb should be kept away from windows.

Classroom areas:

- Keep extension cords and unprotected electrical outlets out of children's reach.
- Cover hot radiators.
- Provide sturdy toys with no small removable parts, of unbreakable materials, and with lead-free paints.
- Use tables with blunt corners.

- Securely anchor all rugs, shelves and bookcases.

- Use safety plugs in electrical outlets and avoid using extension cords.

- Keep small objects out of reach of children.

- Keep electrical cords to appliances out of reach of children.

- Have periodic electrical inspection and fire inspection of entire center.

Poisons:

- Keep all cleaning supplies and medicines locked away from children.

- Avoid any poisonous plants.

Burns:

- Provide guards for all heaters, registers, floor furnaces.

- Have fully charged fire extinguishers available and train each employee in their use.

Outdoor play areas:

- Pad places where children fall. For example, place a sack of foam scraps or an old foam mattress at the foot of a slide.

- Every day check the outdoor area for anything which might cause a child to trip and fall. Remember, children with visual handicaps will not see things other children know to avoid.

- Holes, bumps, or other dangerous areas need to be filled in and smoothed out.

- Fence off an area that is dangerous if it cannot be fixed.

- Sweep any sand on paved areas to avoid slipping.

- Never leave garden tools lying around.

- Remove any poisonous plants.

- Provide close supervision anytime there are puddles on the ground.

- Keep fencing in good repair. Provide a temporary substitute barrier if you have a broken gate, and repair the gate immediately.

- Check for broken glass. When yards are near streets and highways, bottles and cans are sometimes thrown on the playground.

Emergencies:

- Make arrangements with physician or hospital for emergency treatment.

- Keep current information on how to contact parents or guardian.

- Keep up-to-date list of persons to whom child may be released, and personally identify individual before releasing child to his/her custody.

HEALTH

Good health is cricical for every child. A child's health affects not only physical growth and development but mental development as well.

The Nevada Regulations and Standards for Child Care Facilities include regulations which relate to prevention of disease through immunization, the maintenance of health records, first aid, and provisions for action in case of emergencies. Consult this document for specific regulations that may apply to your program.

HEALTH PROBLEMS

A child with a health impairment has less endurance, strength, energy, or alertness than other children. This could be due to a chronic health problem such as asthma, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, or tuberculosis (Generally, hemophilia and epilspsy do not produce the above symptoms of health impairments, but the children will need special precautions if any injury occurs, in the case of hemophelia, or if an epileptic seizure occurs.) All of the above health problems may adversely affect the child's educational performance.

If a child in a program has any of these chronic health problems, it is important that staff members know the implications of the disorder for levels of activity, precautions, signs of distress and emergency treatments.

QUESTIONS TO ASK PARENTS, DOCTORS OR SPECIALISTS

Obtain information from the parents or doctor about the child with a serious health impairment:

- What are the signs or problems to look for?
- What conditions of the child's health should be reported to the doctor?
- What medication will be necessary? Dosage? Frequency?
- Is the teacher to give the medicine? When?
- Are there any changes in diet for the child?
- Should physical activities be restricted?
- What are some things staff should do to help the child with the health problem?
- What kind of special activities should be planned for the child, if any?
- What are some of the things that could be done to help the child accept the health problem?

INSTRUCTIONAL CONSIDERATIONS FOR THE CHILD WITH HEALTH PROBLEMS

There are many things to keep in mind when working with a child with a health impairment. The most important thing is to treat this child as much as possible like any other child. Draw attention to the many things the child can do. Accept the fact that this child has certain limitations but is more like the other children than different.

- Have realistic expectations for a child with a health impairment. Encourage the child to do the things that are possible. If the health impairment limits activity, this child might enjoy doing other activities that are not too strenuous.
- Set realistic and consistent limits for the behavior of children. They need to know what they can and cannot do. They also need to know that the limits are the same each day.

- Express positive feelings to the children. Show affection and allow them to be affectionate to you. Avoid physical punishment.

- Encourage children with health impairments to become independent. Do not overprotect them. Encourage them to learn to do new and different things.

NUTRITION

Proper nutrition is essential to maintain and promote good health and effective learning. The benefits of a good nutritional program, however, are much broader than physical health. A nutrition program should support the overall goals of the program, including socialization, sharing, communication, decision-making, muscle control, eye-hand coordination and development of independence. Snacks and meals should provide opportunities for children to learn self-feeding skills, socially accepted behavior, basic nutrition, cultural and ethnic food practices and to participate in food purchase, preparation and service.

VI

PROGRAM EVALUATION

- CHILD PROGRESS
- PROGRAM DEVELOPMENT AND EXPANSION
- STAFF DEVELOPMENT AND COMPETENCY
- OTHER AREAS OF EVALUATION
- SUMMARY

PROGRAM EVALUATION

Every early childhood special education program, regardless of size, organizational structure, and types of disabilities served, has a need for evaluation of the components of its operation. Program evaluation merely refers to a simple, careful, systematic assessment of the relation between a program's goals and the current program activities.

Attention to evaluating such areas of administrative concern as child progress, staff development and competency, and the relationship between current activities and overall service goals will more than repay the time and thought spent to develop appropriate evaluation procedures. In fact, not only is program evaluation necessary in order to accurately summarize the features of one's current programs, it is absolutely indispensable as a tool for determining, at a practical level, exactly what one should work on next in improving the quality of one's programmatic offerings.

Several common components of evaluation are briefly discussed in this chapter. Adequate site-specific evaluation should enable one to make data-based program decisions, track individual young children and their progress through programs, and conduct longitudinal evaluation of the program.

CHILD PROGRESS

There are a large number of reliable, standardized, and readily available evaluation tools which are appropriate to employ in establishing a child's current levels of performance. (Refer to Chapter 11.) The major task in adequate evaluation is the exercise of care in the selection of an appropriate test, or battery of tests. Adequate testing is that which will suffice to document the appropriate range of behavioral strengths and deficits upon entry of a child into a program. Care should be taken that the testing employed has sufficient sensitivity and range to reflect the changes which the program is designed to produce.

Most programs are designed to focus on individual children's needs. Evaluation of progress will need to be child-specific as well. In this case, evaluation is made possible by program staff providing a careful description of exactly what each child entering the program can do in all important skill areas. If objectives are well-stated, and the goal of current efforts is clear, it is an easy task to observe the child during instruction and to measure progress against entry-level skills. When the criterion on a certain objective is met, the child is ready to go on to the next objective. If the objective is not met within a reasonable length of time, reevaluate a) the time given to instruction, b) the method of instruction, and c) the complexity of the task. It may be necessary to make the instruction periods longer or more frequent, change the type of reinforcer, change the instructional materials, or simplify the task analysis by reducing the size of the steps between immediate training objectives.

The precise format of objectives and evaluation procedures is not as important as having daily evaluation become a natural way of thinking about implementing instruction. Continual observation, assessment, and decisions about instructional programs should become a daily routine and an ongoing classroom occurrence.

PROGRAM DEVELOPMENT AND EXPANSION

A major benefit of any adequate form of program evaluation is the creation of data-based grounds for dropping unneeded services, expanding existing ones, or developing services currently not offered.

Summarizing the information obtained in student evaluations should lead directly to an efficient allocation of staffing resources to meet student needs. Regular periodic assessment may reveal that, with respect to current enrollment, the original programs have resulted in satisfactory gains in areas initially targeted. It may then be possible to direct staff efforts toward service areas that were originally considered too low a priority for special education.

Overall program development cannot be based only on the needs of current students. Effective planning should also take into account the possibility of providing supplemental services or services to populations not currently served. The following is a checklist of program components that, although not exhaustive, suggests areas of activity on which to focus evaluation efforts.

SAMPLE

CHECKLIST FOR PROGRAM DEVELOPMENT

NAME OF CHILD ____________________________________

1. Child's records are maintained in a secure and confidential manner. YES NO
2. Primary language of home and child noted on pupil records. YES NO
3. Written consent of parent/guardian/surrogate prior to assessment. YES NO
4. Written consent of parent/guardian/surrogate obtained prior to placement. YES NO
5. Following persons included in the child evaluation team:
    a. Agency representative YES NO
    b. Child's teacher YES NO
    c. Qualified/certified evaluation personnel YES NO
    d. Parent YES NO
    e. Child YES NO
    f. Other (specify, whose request) ____________________ YES NO
6. Following persons included in the IEP development meeting:
    a. Agency representative YES NO
    b. Child's teacher YES NO
    c. Parents YES NO
    d. Other individuals (specify, whose request) ______________ ____ YES NO
7. Documentation of attempts to arrange mutually agreed-upon time and place for IEP meeting. YES NO
8. Parents indicate, by signature on a form, understanding of IEP. YES NO
9. Parents indicate, by signature on a form, understanding of placement. YES NO
10. Parents indicate, by signature on a form, understanding of educational rights and due process procedures. YES NO
11. Pre and/or post evaluations are current on each individual child. YES NO

12.	Following components of IEP included:		
	a. Present levels of educational performance	YES	NO
	b. Annual goals	YES	NO
	c. Short-term instructional objectives	YES	NO
	d. Special education services to be provided	YES	NO
	e. Related services to be provided	YES	NO
	f. Extent of participation in experiences with non-handicapped children	YES	NO
	g. Projected date for initiation and duration of services	YES	NO
	h. Evaluation procedures	YES	NO
	i. Date(s) for IEP review (at least annually)	YES	NO
	j. Persons responsible for IEP implementation	YES	NO
13.	Professionals meet certification requirement where applicable.	YES	NO
14.	Sufficient space available for educational services.	YES	NO
15.	IEP is developed prior to initial placement for all children.	YES	NO

Notes/Recommendations:

Program development also depends, to a significant degree, on the existence of staff skills. When an evaluation reveals the need to develop a certain kind of program, there is a parallel need to determine if the direct service staff have the appropriate complement of skills. Evaluation of program development needs carries with it the necessity of identifying the training staff will require to provide an adequate program.

STAFF DEVELOPMENT AND COMPETENCY

To properly develop the skills of staff, as well as measure their competency in areas of importance to the program, planners must be familiar with client needs and establish a clear definition of which staff behaviors spell success in activities making up the special education program. (Refer to Chapter IV.)

At this time there are very few standardized testing tools which an administrator may use in either measuring staff performance or identifying skill areas to be developed. Fortunately, there are at least two techniques for staff evaluation which require no special training and are not as subjective as most job-rating judgments. Both of these techniques are based on simple descriptions of adequate job performance.

The first technique requires that the program director, often in conjunction with staff, create a formal job description which lists, in simple descriptive terms, the exact requirements for a particular staff position and the specific behaviors by which adequate performance will be judged. The advantage of having staff involved in developing their own job descriptions is that an agreement as to judgmental criteria is reached long before time for evaluation. It cannot be claimed that one was unaware of the requirements of their position. The deficiency of the system of job-description based evaluation is that it is not always possible to anticipate every requirement associated with a job. It is necessary to update the job description at a regularly scheduled employee performance evaluation, as well as when it is found to contain gaps in its coverage of job-necessary items. Ideally, administrator and staff member, or teacher and aide, should meet at least quarterly, or as required by new job assignments, to update their job descriptions. Weekly meetings of short duration may also be valuable to review student goals and discuss successes or difficulties with current programs.

A second technique of evaluation also stresses description rather than global value judgment. In this technique, supervisors are asked to observe their staff and record those behaviors which seem critical to success in the child-related task at hand. Staff are also asked to provide descriptions of instances of successful and unsuccessful performance in working with children on specific tasks. When a collection of both superior and unsatisfactory performance descriptions is sufficiently large to cover the main features of a position, the list of recorded behaviors is used as a standard for judging the adequacy of a particular staff member's performance.

It should be clear that this technique also has both advantages and drawbacks. The main advantage is that individual staff evaluations are based on actual behavior incidents rather than vague general characteristics or traits. On the negative side, the development of an adequate list of critical incidents is time-consuming. Again, failure to encompass all aspects of appropriate performance may lead to inappropriate evaluation. Finally, it is necessary to carefully examine instances of seemingly inadequate performance to see if they indicate the types of staff training that should be addressed in future efforts to develop staff and program.

In an evaluation of staff there are several sources of bias which one should be alerted to, and which one should attempt to avoid. Several of these sources of evaluational bias are:

1. Halo effect -- the tendency to judge all aspects of a person's behavior on the basis of a single positive or negative attribute or characteristic.

2. Systematic bias -- the rater tends to rate everyone high, low, average, etc.

3. Most recent performance error -- the tendency to base the individual's rating on the most recent behavior rather than on overall performance.

4. Inadequate information error -- resulting from rating an individual without adequate observation or knowledge of performance.

Working to minimize the effects of these sources of evaluation error will greatly improve the credibility of a staff evaluation program.

As we are all aware, evaluation of staff can be extremely uncomfortable for both parties. It is therefore specially important that one treat the individual being evaluated with tact, dignity, and emotional support. An oft-repeated, and appropriate, caution to supervisors is that one should always begin an evaluation by calling attention to what the employee has done well in the period being evaluated. There is a sound behavioral principle behind this advice: appropriate behavior is not specified by concentrating solely on descriptions of what was done incorrectly. In general, we all tolerate having others call attention to our shortcomings when the latter are surrounded by larger numbers of references to what we did correctly. Also, it is important to indicate that any shortcomings are not personal failings, but rather, owing to a need for training, to changes in program requirements, etc. -- insofar as this is actually the case.

As a general point, staff evaluations should be primarily designed to both let staff know how adequate their performance has been, and to work out goals to be accomplished by the next scheduled evaluation. Except in a few rare cases, evaluations of staff, when handled correctly, should engender a sense of staff involvement in the design and management of both the program being offered and their own personal professional development.

OTHER AREAS FOR EVALUATION

Aspects of the program other than those related to direct instruction can and should be evaluated as well. Materials can be evaluated in terms of how often they are used and how effective they are in helping students learn. Room arrangement can be evaluated by observing in what ways areas are used and how often. The teacher may notice that the perceptual games and puzzles area is rarely used. Closer observation may show that children who sit down to play with the puzzles are quickly distracted by other children who are actively playing with wheel toys nearby. The solution may be to move the puzzles to a quieter area of the room. The total classroom atmosphere can be evaluated not only by the progress children make but also in terms of their expressed feelings and attitudes toward the school environment. Are they happy to come to school most days? Are they relaxed and easy-going in the classroom routine? Consistent behavioral or emotional problems may be clues to the teacher that changes should be made in the classroom environment or routine. (Refer to Chapter V.)

PROGRAM EVALUATION
SUMMARY

Overall program evaluation is an absolutely essential management tool. The areas of focus should be the general areas of child progress, program development, and staff competency. In the area of child progress there are a large number of refined and discriminating tools that may be readily adapted for use in the range of activities typically found in early childhood special education programs. Administrators are encouraged to seek professional guidance in the selection, administration, and evaluation of the test(s) most suited to the needs of their programs.

In the area of program development, it was suggested that current student needs, unserved potential service recipients, and staff strengths and weaknesses be the sources of information which guide the evolution of a specific educational program.

In areas of staff competency two general types of evaluative programs were suggested: evaluation based on cooperatively designed job description, and evaluation based on a compilation of critical incidents. Both of these techniques of evaluation are built on simple description of actual on-the-job behaviors, both require participation of the staff being evaluated, and both are consistent with involvement of staff in the overall management and development of the program which their daily activities constitute. These features are consistent with common-sense and the state-of-the-art thinking in industrial and organizational psychology.

Evaluation can be somewhat informal and still effective if the following general steps are observed:

1. Define the goals, objectives, or expected outcomes.

2. Decide what evidence will be accepted to show if the goal has been met. (How will you know if it happens?)

3. Observe systematically and record observations.

4. Make decisions based on the evidence. (You may decide to redefine goals, gather more evidence, or make changes.)

5. After implementing a decision, keep observing, recording, and making changes as necessary until goals are achieved. (Try, try again.)

As a general principle, evaluation involves the establishment of some baseline of behaviors (children's entry-level skills at the start of a program, or the activities of successful teachers and aides) against which the activities of particular individuals are compared. Exactly what constitutes an appropriate baseline will be a matter of creative exploration within each program. However, with a relaxed and flexible attitude, and a little ongoing effort, the results will more than repay the effort. Do not hesitate to contact technical support personnel for help in any areas of evaluation that are providing difficulty.

VII

INTERAGENCY COORDINATION

- ANALYSIS OF RESOURCES AND DATA
- INTERAGENCY AGREEMENTS

INTERAGENCY COORDINATION

Providing services to young handicapped children is rarely, if ever, accomplished by a single entity or agency. Instead, services are likely to be provided by numerous public and private agencies, all fulfilling a part of the needs of the child and his/her parents from referral to service provision. There are many outstanding services available to handicapped children, but there has been little coordination of service. Without coordination and cooperation among agencies, both private and public, services to handicapped children and their parents are likely to be fragmented, discontinuous, and in many cases, absent.

In times of fiscal conservatism and limited budgets such as we are presently experiencing, it is especially important that agencies and service providers seek ways to use most efficiently the resources available in providing a continuum of services.

Agreements between government agencies and between government and private agencies can be used in any number of service areas, such as:

Referral
Identification
Education
Screening
Provision of Educational Services
Provision of Related Services
Development of Program Plans

ANALYSIS OF RESOURCES AND DATA

Interagency cooperation must begin with an analysis of those public and private resources available, responsible agencies, and mandated functions of governmental services. Current Nevada law does not require school districts to provide special education to children below the age of 5. NRS 388.490 states that districts may serve children with vision or hearing handicaps from birth, and mental handicaps from age 3. Some school districts choose to operate early childhood programs as part of their special education services. There are many other agencies available to provide a full continuum of services. Among these are the Department of Human

Resources and its Divisions of Welfare, Mental Hygiene and Mental Retardation, Health, Youth Services, and Rehabilitation; University departments and clinics, medical school; public health organizations; private treatment centers such as Easter Seal, Head Start programs, day care centers and nursery schools. (A Directory of Early Childhood Services for Children with Special Needs is available from the Special Education Branch of the Nevada Department of Education.)

The State of Nevada may consider through the Department of Education and the Department of Human Resources the establishment of a data bank which could provide planning information for agencies and school districts. The system must insure confidentiality, yet serve as a useful information bank to provide a centralized source of data about handicapped children and resources in Nevada.

INTERAGENCY AGREEMENTS

Interagency cooperation agreements may be informal or formal. Informal coordination occurs as individuals working within the delivery system search for services for individuals or groups of clients. A caseworker locates a resource which can provide a service and makes arrangements to share services. These informal agreements can be very effective for individuals or small groups and may lead to expanded cooperation but usually do not put into place a continuum of services.

For more permanent planning and provision of services, more formal agreements may be necessary which specify responsibility for fiscal and personnel resources. Such agreements may take place between governmental agencies such as the Department of Education and the Department of Human Resources to clarify roles and responsibility, or between a local education agency and a community preschool to provide educational services in a less restrictive environment.

Such formal agreements should be prepared with care to avoid misunderstandings and lapses of service. Coordination between several agencies requires an initial planning period prior to the actual coordination of services. Steps to follow in the initial planning period are:

1. Clarify responsibilities of identified agencies.

2. Delineate funding responsibilities.

3. Establish local procedures for identifying, referring, and serving young handicapped children.

4. Secure needed expertise.
5. Determine system of child advocacy.
6. Establish guidelines for confidentiality.
7. Develop list of resources which could be utilized:
    - Early childhood programs, both public and private, that have potential for integrating handicapped children
    - Sources for training for staff development and technical assistance
    - Sources for related services
8. Facilitate parent participation.

Following is a more complete compilation of information elements usually incorporated in interagency agreements:

1. Description of basis for developing the written agreement:
    - Previous ongoing relationship between parties, identification of common need, institution of new service, etc., as foundation for current agreement
    - Legal authority based on federal or state legislation
2. Definitions for agency or program-specific terms used in the agreement.
3. Description of purpose to be achieved through agreement.
4. Mutually agreed-upon goals and/or objectives of the agreement.
5. Eligibility criteria/description for population to be served or affected by agreement.
6. Delineation of specific roles and responsibilities of each party to the agreement.
7. Mutual/shared responsibilities of all parties to the agreement.
8. Specific actions to be taken relative to the program/service identified in agreement (Action Plan).

9. Specific services to be provided by each party.
10. Designation of responsible party or liaison person for implementation of agreement and functions of that role.
11. Specification of meetings (time, dates, frequency) relative to terms of the agreement.
12. Specification of reporting mechanisms between parties of the agreement.
13. Confidentiality assurances relative to sharing of information.
14. Agreement among parties for notification in cases of changes in agency operations.
15. Specification of time period for agreement to remain effective.
16. Schedule for periodic review of agreement.
17. Procedure for modifying or terminating written agreement.
18. Additional assurances.
19. Specification of additional incentives to be provided as a result of the written agreement, i.e., funding additional staff, work space, etc.
20. Signatures of all parties involved in agreement.

CRITICAL ELEMENTS OF INTERAGENCY AGREEMENTS

Not all of the elements listed above need to be included in every type of interagency agreement. However, a list of criteria of essential elements to be included in the majority of agreements developed includes:

1. Statement of clear purpose of agreement between parties with delineation of goals and measurable objectives for the terms of the agreement.
2. Definitions of any terms that could be ambiguous between the parties.
3. Clear delineation of specific program, service or focus for the agreement to facilitate clear communication of the need for and intent of the agreement.

4. Designation of the agency which has first-dollar responsibility for payment of services and specification of other financial or funding arrangement for payment of services.

5. Specific actions, roles and responsibilities of each party to the agreement as well as mutual responsibilities.

6. Designation of staff position(s) within each agency responsible for:

   - implementing the agreement as specified
   - monitoring the implementation
   - negotiating change when necessary to update agreement

7. General administrative procedures for parties affected by the agreement (i.e., specified time period for agreement, mechanism for updating/revising, scheduled meetings set for parties to agreement, confidentiality safeguards, referral mechanisms, information sharing, other assurances).

8. Evaluation design specified and agreed upon by all parties to be used in monitoring implementation of agreement; identification of person(s) responsible for evaluating and sanctions agreed upon to assure its implementation.

VIII

ADDITIONAL REFERENCES AND MATERIALS

PARTIAL LIST OF REFERENCE MATERIALS

Alabama Early Childhood Education Teacher Aide Guide - Bulletin #3
Division of Instruction
Alabama State Department of Education
Montgomery, Alabama 36104

A Parent's Guide to Day Care - DHHS Publication No. OHDS 80-30254
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Child Care and Development Occupation/Competency Based Teaching Modules
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Directory of Early Childhood Services to Children with Special Needs
Special Education Branch
Nevada Department of Education
Capitol Complex
Carson City, Nevada 89710

Early Childhood Facilities
Special Education Section - Division of Elementary & Secondary Education
Office of Instructional Services - Richard F. Kneip Building
South Dakota State Department of Education
Pierre, South Dakota 57501

Facilities Planning Guide for Special Education Programs
National Association of State Directors of Special Education
1201 16th Street, N.W.
Washington, D.C. 20036

Guidelines for Early Childhood Education
Maryland State Department of Education
P.O. Box 8717
Friendship International Airport
Baltimore, Maryland 21240

Children with Health Impairments
Children with Learning Disabilities
Children with Hearing Impairments
Children with Visual Impairments
Children with Orthopedic Handicaps
Children with Mental Retardation
Children with Emotional Disturbance
Children with Speech & Language Impairments
The Status of Children in Head Start Programs
Project Head Start - Educational Materials
U.S. Department of Health and Human Services
Washington, D.C. 20201

Sunshine Series - Basic Development and Developmental Disabilities
The Easter Seal Society for Alaska Crippled Children & Adults, Inc.
P.O. Box 2432
Anchorage, Alaska 99510

When You Care for Handicapped Children
Texas Department of Human Resources
Development Materials
Child Development Program 529-A
P.O. Box 2960
Austin, Texas 78769

PERIODICALS

DEC Communicator and *Journal for the Division of Early Childhood*
Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091
(available to CEC-DEC members or sold separately)

Keys to Early Childhood Education
Capitol Publications, Inc.
2430 Pennsylvania Avenue, N.W.
Washington, D.C. 20037
(monthly ideas from the Cognitively Oriented Curriculum; $57 annual subscription)

The National Newspatch
Oregon School for the Blind
700 Church Street
Salem, Oregon 97310
(Quarterly newsletter for educators of visually impaired preschoolers; $3.00 annual subscription)

Report on Preschool Education
Capitol Publications, Inc.
1300 North 17th Street
Arlington, Virginia 22209
(biweekly newsletter on federal programs for early childhood development; $108 annual subscription)

Topics in Early Childhood Special Education
Aspen Systems Corporation
1600 Research Boulevard
Rockville, Maryland 20850
(quarterly publication focusing on current issues relating to the study and treatment of handicapped preschoolers; $38 annual subscription)

BEST COPY AVAILABLE

AUDIO-VISUAL MATERIALS AVAILABLE ON LOAN FROM NEVADA DEPARTMENT OF EDUCATION SPECIAL EDUCATION BRANCH

The Fortunate Few
(a motion picture that explains how early intervention benefits not only special children, but also their parents, the public schools, and society as a whole)

The Handicapped Child: Infancy Through Preschool
(a series of 8 filmstrips and cassette tapes that brings together current information on assessment and intervention techniques and covers the family crisis, risk factors, initial assessment and intervention, sensory/motor development, cognitive/language development, adaptive behavior, and self-help skills)

Parents Perceptions
(video cassette of group of parents exploring past and present feelings about themselves and their hearing impaired children)

Starting at the Beginning
(slide tape presentation of rationale for early intervention)

Today is Not Forever
(video cassette conversation with two parents of hearing impaired children eight years ago and today)

LIBRARY MATERIALS AVAILABLE ON LOAN
FROM NEVADA DEPARTMENT OF EDUCATION
SPECIAL EDUCATION BRANCH

Basic Development & Developmental Disabilities, Parts 1, 2 & 3 (Alaska)

Competency Based Curriculum Guide: Foundations (District of Columbia Public Schools)

Early Childhood & Family Development Programs Improve the Quality of Life for Low-Income Families, Comptroller General Report to Congress

Early Childhood, by Merle B. Karnes and Richard C. Lee (CEC)

Early Childhood Curriculum Materials: An Annotated Bibliography (TADS)

Evaluating Handicapped Children's Early Education Programs (WESTAR)

Handbook of Preschool Special Education, by Allen A. Mori and Jane Ellsworth Olive

Handicapped Children's Early Education Program Overview & Directory, 78-79, 79-80, 80-81

Instructional Materials for the Handicapped: Birth Through Early Childhood, by Arden R. Thorum

Language & Speech Activities, by Cheryl Walker Prichard

Language & Speech Development, by Cheryl Walker Prichard

Lasting Effects After Preschool, U.S. Department of Health, Education & Welfare (Lazar-Cornell Study)

Parent Involvement (South Dakota Preschool Programs for the Handicapped)

Parents as Teachers of Their Handicapped Children: An Annotated Bibliography, prepared by Mark R. Wolery, edited by Marcia J. May (WESTAR)

Perspectives on Measurement: A Collection of Readings for Educators of Young Handicapped Children, edited by Talbot Black (TADS)

Program Strategies for Cultural Diversity: Proceedings of the 1980 Minority Leadership Workshop: Handicapped Children's Early Education Program (WESTAR and TADS)

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Project Head Start Mainstreaming Series:
  Children with Health Impairments
    " " *Learning Disabilities*
    " " *Hearing Impairments*
    " " *Visual Handicaps*
    " " *Orthopedic Handicaps*
    " " *Mental Retardation*
    " " *Emotional Disturbance*
    " " *Speech & Language Impairments*

Serving Young Handicapped Children in Rural America, written and edited by Talbot Black, David Gilderman, Joyce Jackson, Michael Woodard (TADS)

Sourcebook for Noncategorical Preschool Programs (Louisiana State Department of Education)

South Dakota Preschool Curriculum

Special Needs of the Young Exceptional Child (Alaska)
  Hearing Disabilities
  Language Disabilities
  Learning Disabilities
  Mental Retardation
  Social and Emotional Disabilities
  Visual Disabilities

Sunshine Series (Alaska)

Teaching Young Handicapped Children: A Guide for Preschool and the Primary Grades, by Betty A. Hare and James M. Hare

What's Where? Catalog of Products Developed by HCEEP Projects (WESTAR)

When You Care for Handicapped Children (Texas Department of Human Resources)

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BROCHURES AND DOCUMENTS AVAILABLE IN QUANTITY AT NO CHARGE FROM THE NEVADA DEPARTMENT OF EDUCATION SPECIAL EDUCATION BRANCH

The Argument for Early Intervention

Chart of Normal Development

Directory of Early Childhood Services to Children with Special Needs

Early Childhood Special Education

Evaluation & Confidentiality Rights

From Crib to Kindergarten (wheel)

One Step at a Time

Reaching Handicapped Children in Their Early Years

Special Education Rights of Parents and Children

Standards for Administration of Special Education Programs

Will Your Child Be Ready...

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